



# भारत का राजपत्र The Gazette of India

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सं. 30] नई दिल्ली, अगस्त 16—अगस्त 22, 2020, शनिवार/श्रावण 25—श्रावण 31, 1942  
No. 30] NEW DELHI, AUGUST 16—AUGUST 22, 2020, SATURDAY/SRAVANA 25—SRAVANA 31, 1942

इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह पृथक संकलन के रूप में रखा जा सके  
Separate Paging is given to this Part in order that it may be filed as a separate compilation

भाग II—खण्ड 3—उप-खण्ड (ii)  
PART II—Section 3—Sub-section (ii)

भारत सरकार के मंत्रालयों (रक्षा मंत्रालय को छोड़कर) द्वारा जारी किए गए सांविधिक आदेश और अधिसूचनाएं  
Statutory Orders and Notifications Issued by the Ministries of the Government of India  
(Other than the Ministry of Defence)

विदेश मंत्रालय

(सी.पी.वी. प्रभाग)

नई दिल्ली, 29 जुलाई, 2020

**का.आ. 676.**—राजनयिक और कौंसुलीय अधिकारी (शपथ एवं फीस) के अधिनियम, 1948 की धारा 2 के खंड (क) के अनुसरण में वैधानिक आदेश।

एतद्वारा, केंद्र सरकार भारत के प्रधान कौंसुलावास, हैमवर्ग में श्री मनीष, सहायक अनुभाग अधिकारी को दिनांक 29 जुलाई 2020 से सहायक कौंसुलर अधिकारी के तौर पर कौंसुलर सेवाओं के निर्वहन के लिए प्राधिकृत करती है।

[फा. सं. टी-4330/01/2016]

विष्णु कुमार शर्मा, निदेशक (सी.पी.वी.)

## MINISTRY OF EXTERNAL AFFAIRS

(CPV DIVISION)

New Delhi, the 29th July, 2020

**S.O. 676.**—Statutory Order in pursuance of the clause (a) of the Section 2 of the Diplomatic and Consular Officers (Oaths and fees) Act, 1948 (41 of 1948), the Central Government hereby appoints Shri Manish, Assistant Section Officer as Assistant Consular Officer in Consulate General of India, Hamburg to perform the Consular services with effect from 29 July, 2020.

[F. No. T-4330/01/2016]

VISHNU KUMAR SHARMA, Director (CPV)

## कार्मिक, लोक शिकायत तथा पेंशन मंत्रालय

(कार्मिक और प्रशिक्षण विभाग)

नई दिल्ली, 19 अगस्त, 2020

**का.आ. 677.**—केन्द्र सरकार, एतद्वारा दिल्ली विशेष पुलिस स्थापना अधिनियम, 1946 (1946 की अधिनियम संख्या 25) की धारा 5 की उप-धारा (1) सपठित धारा 6 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए आंध्र प्रदेश राज्य सरकार, गृह (एससी.ए) विभाग अधिसूचना जी.ओ. एमएस सं. 111, दिनांक 12.09.2019 सपठित इसकी संशोधित अधिसूचना जी.ओ. एमएस सं. 172, गृह (एससी.ए) विभाग, दिनांक 24.12.2019 सपठित इसकी शुद्धि पत्र, जिसे जी.ओ. एमएस सं. 13, गृह (एससी.ए) विभाग, दिनांक 20.01.2020 के माध्यम से जारी किया गया और सपठित इसकी संशोधित अधिसूचना जी.ओ. एमएस सं. 72, गृह (एससी.ए) विभाग, दिनांक 25.06.2020, के माध्यम से जारी सहमति से पिदुगुरल्ला मंडल के कोणांकी गांव, केसानुपल्ली और दाचेपल्ली मंडल के नादीकुदी गांव, गुंटुर जिला में चूना पत्थर के अवैध खनन/खदान क्रिया और अवैध परिवहन के संबंध में निम्नलिखित सारणी में उल्लिखित मामलों में किए गए अपराध(धों) के अन्वेषण करने के लिए तथा ऐसे अपराध(धों) से जुड़े या उससे संबद्ध किसी दुष्प्रयास, दुष्प्रेरणा और षड्यंत्र एवं/अथवा उसी संव्यवहार में किए गए या उन्हीं तथ्यों से उत्पन्न किसी अन्य अपराध(धों) का अन्वेषण करने के लिए दिल्ली विशेष पुलिस स्थापना के सदस्यों की शक्तियों और क्षेत्राधिकार का विस्तार समस्त आंध्र प्रदेश राज्य में करती है:-

क्र.सं.	अपराध सं. और कानून की धारा	थाना के नाम
1	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 308/2018	पिदुगुरल्ला
2	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 309/2018	पिदुगुरल्ला
3	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 310/2018	पिदुगुरल्ला
4	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और	पिदुगुरल्ला



	विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 184/2018	
16	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 185/2018	दाचेपल्ली
17	भारतीय दण्ड संहिता की धारा 379, 386, 420, 447, पीडीपीपी अधिनियम की धारा 3, एमएम (डीएण्डआर) अधिनियम, 1957 की धारा 21 सपठित एपी एमएमसी नियम, 1966 की धारा 26, विस्फोटक अधिनियम, 1884 की धारा 9 (बी) और विस्फोटक पदार्थ अधिनियम, 1908 की धारा 3 के अंतर्गत अपराध सं. 186/2018	दाचेपल्ली

[फा. सं. 228/31/2019-एवीडी-II]

एस. पी. आर. त्रिपाठी, अवर सचिव

**MINISTRY OF PERSONNEL, PUBLIC GRIEVANCES AND PENSIONS****(Department of Personnel and Training)**

New Delhi, the 19th August, 2020

**S.O. 677 .**—In exercise of the powers conferred by sub section (1) of Section 5 read with Section 6 of the Delhi Special Police Establishment Act, 1946 (Act No. 25 of 1946), the Central Government with the consent of the State Government of Andhra Pradesh, issued vide Home (SC.A) Department Notification G.O. Ms. No. 111, dated 12.09.2019 r/w its amendment Notification G.O. Ms. No. 172, Home (SC.A) Department, dated 24.12.2019 r/w its Corrigendum issued vide G.O. Ms. No. 13, Home (SC.A) Department, dated 20.01.2020 and r/w amendment Notification G.O. Ms. No. 72, Home (SC.A) Department, dated 25.06.2020, hereby extends the powers and jurisdiction of the members of the Delhi Special Police Establishment to the whole State of Andhra Pradesh for investigation into the offence(s) relating to illegal mining/quarrying and illegal transportation of Limestone in Konanki Village of Piduguralla Mandal, Kesanupalli and Nadikudi Villages of Dachepalli Mandal, Guntur District in the cases mentioned in the following table and any attempt, abetment and conspiracy in relation to or in connection with such offence(s) and/or for any other offence committed in the course of the same transaction or arising out of the same facts:-

Sl. No.	Cr. No. & Sec. of Law	Name of PS
1	Cr. No. 308/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
2	Cr. No. 309/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
3	Cr. No. 310/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
4	Cr. No. 311/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
5	Cr. No. 312/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
6	Cr. No. 313/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
7	Cr. No. 314/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of	Piduguralla



	Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	
8	Cr. No. 315/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
9	Cr. No. 316/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
10	Cr. No. 317/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
11	Cr. No. 318/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Piduguralla
12	Cr. No. 181/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli
13	Cr. No. 182/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli
14	Cr. No. 183/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli
15	Cr. No. 184/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli
16	Cr. No. 185/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli
17	Cr. No. 186/2018 U/s 379, 386, 420, 447 IPC, Sec. 3 of PDPP Act, Sec. 21 of MM (D&R) Act, 1957 r/w 26 of AP MMC Rules, 1966, Sec. 9 (B) of Explosives Act, 1884 & Sec. 3 of Explosive Substances Act, 1908.	Dachepalli

[F. No. 228/31/2019-AVD-II]

S. P. R. TRIPATHI, Under Secy.

**कृषि एवं किसान कल्याण मंत्रालय**

(कृषि, सहकारिता एवं किसान कल्याण विभाग)

(राजभाषा प्रभाग)

नई दिल्ली, 20 जुलाई, 2020

**का.आ. 678 .—**केंद्रीय सरकार, राजभाषा (संघ के शासकीय प्रयोजनों के लिए प्रयोग) नियम, 1976 के नियम 10 के उप नियम (4) के अनुसरण में कृषि, सहकारिता एवं किसान कल्याण विभाग, कृषि एवं किसान कल्याण मंत्रालय के प्रशासनिक नियंत्रणाधीन निम्नलिखित संस्थान को जिसके 80 प्रतिशत कर्मचारियों ने हिंदी का कार्यसाधक ज्ञान प्राप्त कर लिया है, अधिसूचित करती है: -

**चौ. चरण सिंह राष्ट्रीय कृषि विपणन संस्थान,**  
**कोटा रोड, बम्बाला, प्रताप नगर,**  
**जयपुर – 302033, राजस्थान**

[फा. सं. 3-3/2011-रा.भा.नी.]

अश्वनी कुमार, संयुक्त सचिव

**MINISTRY OF AGRICULTURE AND FARMERS WELFARE****(Department of Agriculture, Cooperation and Farmers Welfare)****(OFFICIAL LANGUAGE DIVISION)**

New Delhi, the 20th July, 2020

**S.O. 678 .—**In pursuance of Sub Rule (4) of the Rule 10 of the Official Languages (Use for Official Purposes of the Union) Rules, 1976 the Central Government hereby notifies the following Institute which is under the administrative control of the Department of Agriculture, Cooperation and Farmers Welfare, Ministry of Agriculture and Farmers Welfare whereof 80% staff have acquired the working knowledge of Hindi-

**CCS National Institute Of Agricultural Marketing,  
Kota Road, Bambala, Pratap Nagar,  
Jaipur, Rajasthan-302033**

[F. No. 3-3/2011-Official Language Policy]

ASHWANI KUMAR, Jt. Secy.

नई दिल्ली, 20 जुलाई, 2020

**का.आ. 679 .—**केंद्रीय सरकार, राजभाषा (संघ के शासकीय प्रयोजनों के लिए प्रयोग) नियम, 1976 के नियम 10 के उप नियम (4) के अनुसरण में कृषि, सहकारिता एवं किसान कल्याण विभाग, कृषि एवं किसान कल्याण मंत्रालय के संबद्ध कार्यालय वनस्पति संरक्षण, संगरोध एवं संग्रह निदेशालय, फरीदाबाद के अंतर्गत निम्नलिखित प्रशासनिक नियंत्रणाधीन कार्यालयों को जिनके 80 प्रतिशत कर्मचारीवृन्द ने हिंदी का कार्यसाधक ज्ञान प्राप्त कर लिया है, अधिसूचित करती है: -

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| 1. केंद्रीय एकीकृत नाशीजीव प्रबंधन केंद्र, प्लॉट नं.- 195/663, पार्क नगर, पी.ओ. वरमुंडा कॉलोनी, भुवनेश्वर -751003 (ओडिशा)                          | 2. टिड्डा मंडल कार्यालय, एनएच-15, आईटीआई, रेलवे क्रासिंग के पास, फलौदी, जिला - जोधपुर-342301 (राजस्थान)                |
| 3. केंद्रीय एकीकृत नाशीजीव प्रबंधन केंद्र, लक्ष्मी निवास, कृषि भवन, कांके रोड, रांची - 834008 (झारखंड)   | 4. टिड्डा मंडल कार्यालय, कलेक्ट्रेट कार्यालय के नजदीक, चुरू - 331001 (राजस्थान)  |
| 5. केंद्रीय एकीकृत नाशीजीव प्रबंधन केंद्र, मकान नं. 82/05, एच.पी.एस., साई भवन, अरावली मार्ग, न्यू सांगानेर रोड, मानसरोवर, जयपुर -302020 (राजस्थान) | 6. टिड्डा मंडल कार्यालय, राजपूत समाजवाड़ी के पास, रावलवाड़ी रिलोकेशन साईट, रघुवंशी नगर, जिला भुज (कच्छ)-370,001 गुजरात |
| 7. टिड्डा मंडल कार्यालय, बसनी रोड, नागौर - 341001 (राजस्थान)   | 8. टिड्डा मंडल कार्यालय, एन.एच.-62, आकाशवाणी के पास, बीकानेर रोड, सूरतगढ़ - 335804 (राजस्थान)                          |
| 9. वनस्पति संगरोध केंद्र, पी.ओ. दुआलजोत, वाया-नक्सलवाड़ी पानीटंकी, दार्जिलिंग -734429 (पश्चिम बंगाल)   | 10. वनस्पति संगरोध केंद्र, सेक्टर-ई, जानकीपुरम रिंग रोड, इंजीनियरिंग कॉलेज क्रासिंग के पास, लखनऊ -226021 उत्तर प्रदेश  |

[फा. सं. 3-3/2011-रा.भा.नी.]

अश्वनी कुमार, संयुक्त सचिव

New Delhi, the 20th July, 2020

**S.O. 679 .**—In pursuance of Sub Rule (4) of the Rule 10 of the Official Language (Use for Official Purposes of the Union) Rules, 1976 the Central Government hereby notifies the following offices which are under the administrative control of the Directorate of Plant Protection, Quarantine & Storage. Faridabad an attached office of the Department of the Agriculture, Cooperation & farmers Welfare, Ministry of Agriculture & Farmers Welfare whereof 80% staff have acquired the working knowledge of Hindi:—

- |  |   |
|--|---|
| 1. Central Integrated Pest Management Centre,<br>Plot No. 195/663, Paika Nagar,<br>P.O. Burmmunda Colony,<br><b>Bhubaneswar (Odisha) -751 003,</b>                       | 2. Locust Circle Office<br>N.H.15, Near I.T.I Railway Crossing,<br><b>Phalodi</b> , District - Jodhpur- 342301<br>(Rajasthan)                           |
| 3. Central Integrated Pest Management Centre,<br>Laxmi Niwas, Krishi Bhawan, Kanke Road,<br><b>Ranchi (Jharkhand)-834008</b>   | 4. Locust Circle Office,<br>Near Collectorate Office,<br><b>Churu</b> -331001 (Rajasthan)   |
| 5. Central Integrated Pest Management Centre,<br>House No. 82/05, HPS, Sai Bhawan, Arawali<br>Marg, New Sanganer Road, Mansarovar, <b>Jaipur</b><br>(Rajasthan) -302020, | 6. Locust Circle Office,<br>Near Rajput Samajwari, Rawalwari Relocation<br>Sight, Raghuvanshi Nagar,<br>District <b>Bhuj (Kutch)</b> , Gujarat – 370001 |
| 7. Locust Circle Office,<br>Basni Road,<br><b>Nagaur</b> -341001 (Rajasthan)   | 8. Locust Circle Office,<br>N.H.- 62, Near Akashwani, Bikaner Road<br><b>Suratgarh</b> - 335804 (Rajasthan)   |
| 9. Plant Quarantine Station,<br>NH-31-C, P.O. DulalJote, Via- Naxalbari,<br><b>Panitanki</b> , Darjeeling-734 429 (W.B)  | 10. Plant Quarantine Station,<br>Sector E, Jankipuram, Ring Road,<br>Near Engineeering College Crossing<br><b>Lucknow</b> , Uttar Pradesh-226021        |

[F. No. 3-3/2011-Official Language Policy]

ASHWANI KUMAR, Jt. Secy.

नई दिल्ली, 20 जुलाई, 2020

**का.आ. 680 .**—केंद्रीय सरकार, राजभाषा (संघ के शासकीय प्रयोजनों के लिए प्रयोग) नियम, 1976 के नियम 10 के उप नियम (4) के अनुसरण में कृषि एवं किसान कल्याण मंत्रालय, कृषि, सहकारिता एवं किसान कल्याण विभाग के स्वायत्त संगठन राष्ट्रीय सहकारी प्रशिक्षण परिषद, हौज खास, नई दिल्ली के प्रशासनिक नियंत्रणाधीन निम्नलिखित कार्यालयों को, जिनके 80 प्रतिशत कर्मचारियों ने हिंदी का कार्यसाधक ज्ञान प्राप्त कर लिया है, अधिसूचित करती है: -

1. सहकारी प्रबंध संस्थान,  
सहकारी कॉम्पलैक्स, लाम्फेलपेट,  
इम्फाल (मणिपुर)- 795004
2. क्षेत्रीय सहकारी प्रबंध संस्थान,  
67, पद्मनाभनगर, बनशंकरा, II स्टेज,  
बेंगलुरु – 560070

[फा. सं. 3-3/2011-रा.भा.नी.]

अश्वनी कुमार, संयुक्त सचिव

New Delhi, the 20th July, 2020

**S.O. 680 .**—In pursuance of Sub Rule (4) of the Rule 10 of the Official Languages (Use for Official Purposes of the Union) Rules, 1976 the Central Government hereby notifies the following offices which are under the administrative control of the National Council For Cooperative Training an Autonomous organization of the Department of Agriculture, Cooperation & Farmers Welfare, Ministry of Agriculture & Farmers Welfare whereof 80% staff have acquired the working knowledge of Hindi.

1. **Institute of Cooperative Management,  
Cooperative Complex,  
Lamphelpat, Imphal-795004**
2. **Regional Institute of Cooperative Management,  
67 Padmanabhanagar, Banshankari,  
2<sup>nd</sup> stage, Bengaluru-560070**

[F. No. 3-3/2011-Official Language Policy]

ASHWANI KUMAR, Jt. Secy.

### स्वास्थ्य और परिवार कल्याण मंत्रालय

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 681.**—मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 की उप-धारा (1) उपबंध करती है कि केन्द्रीय सरकार सामान्यतः उक्त अधिनियम के उपबंधों को कार्यान्वित करने हेतु, उक्त अधिनियम और उसके अधीन बनाए गए नियमों से संगत मार्गदर्शन बना सकेगी;

और उक्त धारा की उप-धारा(2), अन्य बातों के साथ-साथ, केन्द्रीय सरकार को रक्तदाता चयन और रक्तदाता रेफरल मार्गदर्शन, 2018 बनाने के लिए सशक्त करती है;

अतः, अब, केन्द्रीय सरकार मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए इस अधिसूचना से उपाबद्ध अनुसूची के अनुसार "रक्तदाता चयन और रक्तदाता रेफरल मार्गदर्शन, 2018" अधिसूचित करती है।

[फा. सं. टी-11020/50/1999-नाको (पी एंड सी)]

आलोक सक्सेना, संयुक्त सचिव

### MINISTRY OF HEALTH AND FAMILY WELFARE

New Delhi, the 14th August, 2020

**S.O. 681.**—Whereas sub-section (1) of section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017) provides that the Central Government may make guidelines consistent with the said Act and any rules made there under, generally to carry out the provisions of the said Act;

And whereas, sub-section (2) of the said section, *inter alia*, empowers the Central Government to make the Blood Donor Selection and Blood Donor Referral Guidelines, 2018;

Now, therefore, in exercise of the powers conferred by section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017), the Central Government hereby notifies the "Blood Donor Selection and Blood Donor Referral Guidelines, 2018 as per the Schedule annexed to this notification.

[F. No. T-11020/50/1999-NACO(P&C)]

ALOK SAXENA, Jt. Secy.

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## **SCHEDULE**

### **Blood Donor Selection**

**and**

### **Blood Donor Referral Guidelines, 2018**

National Blood Transfusion Council  
National AIDS Control Organisation  
Ministry of Health and Family Welfare  
Government of India  
New Delhi



1. **Introduction.**—The primary responsibility of a Blood Transfusion Service is to provide a safe, sufficient and timely supply of blood and blood components. In fulfilling this responsibility, the Blood Transfusion Service should ensure that the act of blood donation is safe and causes no harm to the donor. It should build and maintain a pool of safe, voluntary non-remunerated blood donors and take all necessary steps to ensure that the products derived from donated blood are efficacious for the recipient, with a minimal risk of any infection that could be transmitted through transfusion.
2. **Objectives.**—The donor selection criteria recommended in these guidelines apply to donors of whole blood, red cells, platelets, plasma and other blood components, donated as whole blood or through apheresis, including plasma for fractionation.

Whilst these guidelines are designed to promote best practise in Blood Transfusion Services to ensure the collection of donations from the lowest risk donors possible.

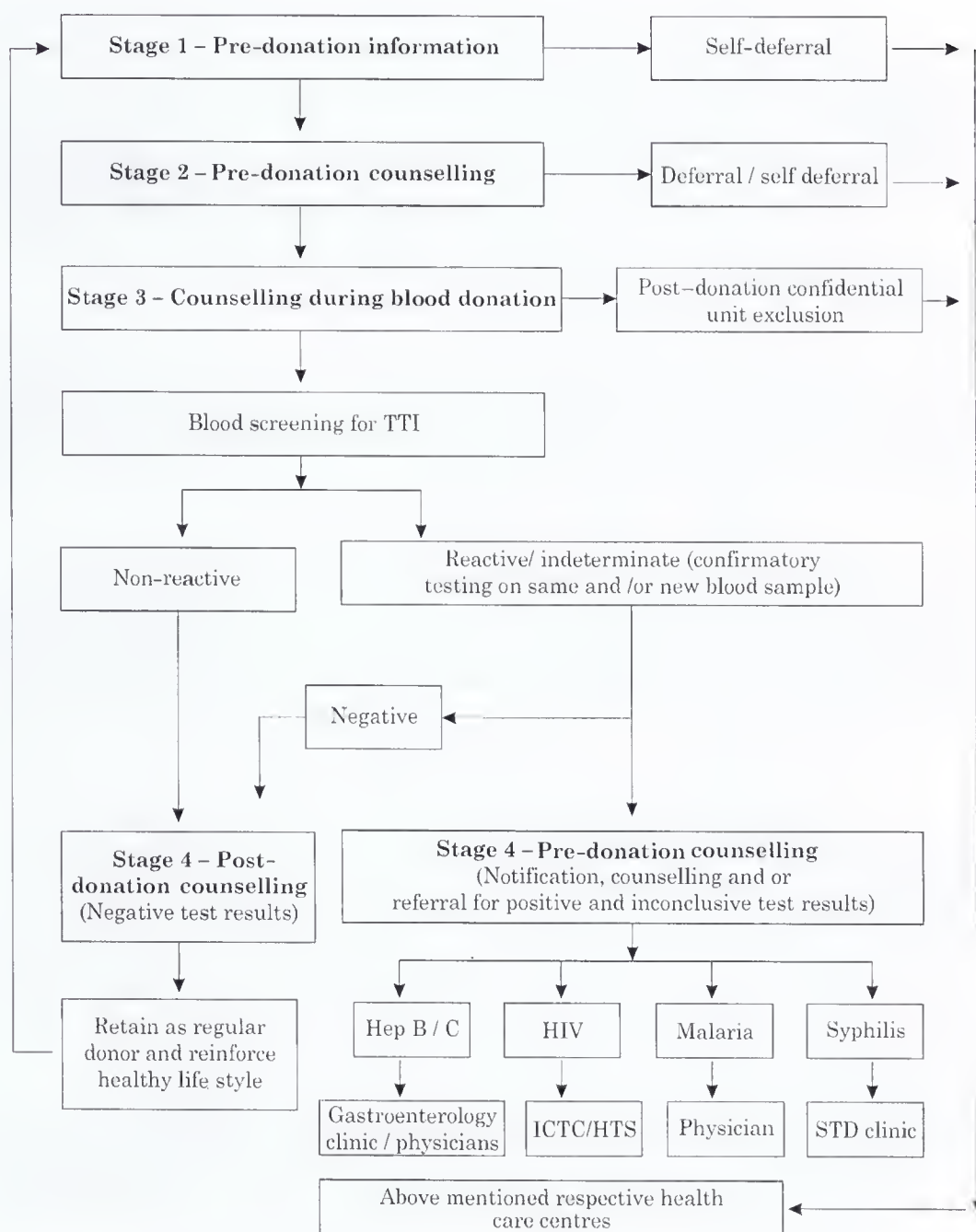
3. **Donor Recruitment and Retention.**—

- (i) Blood should be accepted only from voluntary, non-remunerated, low risk, safe and healthy donors.
- (ii) Efforts should be directed towards encouraging and retaining adequate numbers of repeat donors.
- (iii) Donors should be appropriately recognised and thanked for their contribution.
- (iv) The blood bank should educate donors prior to collection of blood regarding the risk of blood donation and transfusion transmissible infections.

4. **Donor Selection.**—(1)The steps for donor selection include-

- (a) Pre-donation information,
  - (b) Pre-donation counselling,
  - (c) Donor Questionnaire and Health check-up,
  - (d) Counselling during blood donation,
  - (e) Post-donation counselling.
- (2) Counselling of blood donors is to be provided by trained blood donor counsellors maintaining privacy and confidentiality. All blood banks may also train their donor organisers or medical officers to undertake counselling, in case a dedicated manpower is not available. A medical officer with minimum MBBS qualification should be responsible for reviewing the donor's health conditions and performing physical examination of the donor. The final call on donor selection is to be taken by the medical officer.

## Stages of Blood Donor Counselling



### 5. *Pre-donation Information*(1) It should include,—

- (i) Nature and use of blood and its components and the importance of maintaining healthy lifestyles,
- (ii) Eligibility for blood donation,
- (iii) Rationale for the donor questionnaire and pre-donation health assessment,

- (iv) Options for the donor to withdraw or self-defer at any time before, during or after donation,
  - (v) Blood donation process and potential adverse donor reactions,
  - (vi) Common Transfusion Transmitted Infection, modes of transmission and window period,
  - (vii) Basic information on tests performed on donated blood,
  - (viii) Possible consequences for donors and donated blood in the case of abnormal Transfusion Transmitted Infection test results.
- (2) It can be done as a one-on-group and integrated with the activities undertaken for donor recruitment and retention.
6. **Pre-donation Counselling.**-(1) It should focus on the donor and preferably be done one-on-one.
- (2) The objectives include:
- (i) Understanding of Donor Questionnaire to enable correct responses,
  - (ii) Reiterate understanding of Transfusion Transmitted Infection testing and the disclosure of results,
  - (iii) Clarify any misunderstanding about donor selection, blood donation and blood screening,
  - (iv) Explain self-deferral,
  - (v) Explain temporary and permanent deferral,
  - (vi) Familiarise donor to process of blood donation,
  - (vii) Obtain donor's Informed consent.
7. **Donor Questionnaire and Health Check-up.**(1) The donor questionnaire and health check-up is administered to every prospective donor to enable a quick history taking, limited physical examination and blood test. A questionnaire shall be prepared in English and Local languages which is simple and easy to understand to be answered by the donor. For donors who are illiterate, assistance should be given by counsellor or donor registration staff.
- (2) Demographic details of the donor, date and time of donor selection and donation shall be registered. Informed consent shall be obtained in writing from the donors on the questionnaire.
- (3) Prior to blood donation, the consent of the donor shall be obtained in writing with donor's signature or thumb impression after the procedure is explained and the donor is informed regarding testing of blood for all mandatory tests for safety of recipients. The donor shall be provided an opportunity to ask questions and refuse consent.
8. **Donor Consent.** Donor consent shall be taken for the following understanding that:
- (1) Blood donation is a totally voluntary act and no inducement or remuneration has been offered.
  - (2) Donation of blood or its components is a medical procedure and that by donating voluntarily, I accept the risk associated with this procedure.
  - (3) My donated blood and plasma recovered from my donated blood may be sent for plasma fractionation for preparation of plasma derived medicines, which may be used for larger patient population and not just this blood bank.
  - (4) My blood will be tested for hepatitis B, hepatitis C, malaria parasite, HIV or AIDS and Syphilis diseases in addition to any other screening tests required to ensure blood safety.
  - (5) I would like to be informed about any abnormal test results done on my donated blood Yes or No

**Blood Donor Selection Criteria**

<b><u>General Criteria</u></b>		
<b>S.No.</b>	<b>Criteria</b>	<b>Recommendations</b>
1.	Wellbeing	The donor shall be in good health, mentally alert and physically fit and shall not be inmates of jail or any other confinement.  “Differently abled” or donor with communication and sight difficulties can donate blood provided that clear and confidential communication can be established and he or she fully understands the donation process and gives a valid consent.
2.	Age	Minimum age 18 years Maximum age 65 years First time donor shall not be over 60 years of age, for repeat donor upper limit is 65 years. For aphaeresis donors 18-60 years
3.	Whole blood volume collected and weight of donor	350 ml–45 kg 450ml–more than 55 kg Apheresis–50 kg
4.	Donation interval	For whole blood donation, once in three months (90 days) for males and four months (120 days) for females.  For apheresis, at least 48 hours interval after platelet or plasma – apheresis shall be kept (not more than 2 times a week, limited to 24 in one year)  After whole blood donation a plateletpheresis donor shall not be accepted before 28 days.  Apheresis platelet donor shall not be accepted for whole blood donation before 28 days from the last platelet donation provided reinfusion of red cell was complete in the last plateletpheresis donation. If the reinfusion of red cells was not complete then the donor shall not be accepted within 90 days.  A donor shall not donate any type of donation within 12 months after a bone marrow harvest, within 6 months after a peripheral stem cell harvest.
5.	Blood pressure	100-140mm Hg systolic 60-90 mm Hg diastolic with or without medications.  There shall be no findings suggestive of end organ damage or secondary complication (cardiac, renal, eye or vascular) or history of feeling giddiness, fainting made out during history and examination. Neither the drug nor its dosage should have been altered in the last 28 days.
6.	Pulse	60-100 Regular
7.	Temperature	Afebrile; 37°C or 98.4°F
8.	Respiration	The donor shall be free from acute respiratory disease.

9.	Haemoglobin	>or =12.5g/dL Thalassemia trait may be accepted, provided haemoglobin is acceptable.
10.	Meal	The donor shall not be fasting before the blood donation or observing fast during the period of blood donation and last meal should have been taken at least 4 hours prior to donation. Donor shall not have consumed alcohol and show signs of intoxication before the blood donation. The donor shall not be a person having regular heavy alcohol intake.
11.	Occupation	The donor who works as air crew member, long distance vehicle driver, either above sea level or below sea level or in emergency services or where strenuous work is required, shall not donate blood at least 24 hours prior to their next duty shift. The donor shall not be a night shift workers without adequate sleep.
12.	Risk behaviour	The donor shall be free from any disease transmissible by blood transfusion, as far as can be determined by history and examination. The donor shall not be a person considered “at risk” for HIV, hepatitis B or C infections (transgender, men who have sex with men, Female sex workers, Injecting drug users, persons with multiple sexual partners or any other high risk as determined by the medical officer deciding fitness to donate blood).
13.	Travel and residence	The donor shall not be a person with history of residence or travel in a geographical area which is endemic for diseases that can be transmitted by blood transfusion and for which screening is not mandated or there is no guidance in India.
14.	Donor skin	The donor shall be free from any skin diseases at the site of phlebotomy. The arms and forearms of the donor shall be free of skin punctures or scars indicative of professional blood donors or addiction of self-injected narcotics.
<b><u>Physiological Status for Women</u></b>		
15.	Pregnancy or recently delivered	Defer for 12 months after delivery
16.	Abortion	Defer for 6 months after abortion
17.	Breast feeding	Defer for total period of lactation
18.	Menstruation	Defer for the period of menstruation
<b><u>Non-specific Illness</u></b>		
19.	Minor non-specific symptoms including but not limited to general malaise, pain, headache	Defer until all symptoms subside and donor is afebrile
<b><u>Respiratory (Lung) Diseases</u></b>		
20.	Cold, flu, cough, sore throat or acute	Defer until all symptoms subside and donor is afebrile



	sinusitis	
21.	Chronic sinusitis	Accept unless on antibiotics
22.	Asthmatic attack	Permanently defer
23.	Asthmatics on steroids	Permanently defer
<b><u>Surgical Procedures</u></b>		
24.	Major surgery	Defer for 12 months after recovery. (Major surgery being defined as that requiring hospitalisation, anaesthesia (general or spinal) had Blood transfusion and or or had significant blood loss)
25.	Minor surgery	Defer for 6 months after recovery
26.	Received blood transfusion	Defer for 12 months
27.	Open heart surgery including by-pass surgery	Permanently defer
28.	Cancer surgery	Permanently defer
29.	Tooth extraction	Defer for 6 months after tooth extraction
30.	Dental surgery under anaesthesia	Defer for 6 months after recovery
<b><u>Cardio-vascular Diseases (Heart Disease)</u></b>		
31.	Has any active symptom (Chest pain, shortness of breath, swelling of feet)	Permanently defer
32.	Myocardial infarction (heart attack)	Permanently defer
33.	Cardiac medication (digitalis, nitro-glycerine)	Permanently defer
34.	Hypertensive heart disease	Permanently defer
35.	Coronary artery disease	Permanently defer
36.	Angina pectoris	Permanently defer
37.	Rheumatic heart disease with residual damage	Permanently defer
<b><u>Central Nervous System or Psychiatric Diseases</u></b>		
38.	Migraine	Accept if not severe and occurs at a frequency of less than once a week
40.	Convulsions and epilepsy	Permanently defer
41.	Schizophrenia	Permanently defer

42.	Anxiety and mood disorders	Accept person having anxiety and mood (affective) disorders like depression or bipolar disorder, but is stable and feeling well on the day regardless of medication .
<b><u>Endocrine Disorders</u></b>		
43.	Diabetes	Accept person with diabetes mellitus well controlled by diet or oral hypoglycaemic medication, with no history of orthostatic hypotension and no evidence of infection, neuropathy or vascular disease (in particular peripheral ulceration).  Permanently defer person requiring insulin and/or complications of Diabetes with multi organ involvement.  Defer if oral hypoglycaemic medication has been altered or dosage adjusted in last 4 weeks.
44.	Thyroid disorders	Accept donations from individuals with benign thyroid disorders if euthyroid (Asymptomatic goitre, history of viral thyroiditis, auto immune hypo thyroidism)  Defer if under investigation for thyroid disease or thyroid status is not known  Permanently defer if: <ol style="list-style-type: none"> <li>1) Thyrotoxicosis due to Graves' Disease</li> <li>2) Hyper or hypo thyroid</li> <li>3) History of malignant thyroid tumours</li> </ol>
45.	Other endocrine disorders	Permanently defer
<b><u>Liver Diseases and Hepatitis infection</u></b>		
46.	Hepatitis	Known hepatitis B, C— Permanently defer Unknown hepatitis—Permanently defer Known hepatitis A or E— defer for 12 months
47.	Spouse or partner or close contact of individual suffering with hepatitis,	Defer for 12 months
48.	At risk for hepatitis by tattoos, acupuncture or body piercing, scarification and any other invasive cosmetic procedure by self or spouse or partner	Defer for 12 months
49.	Spouse or partner of individual receiving transfusion of blood or components	Defer for 12 months
50.	Jaundice	Accept donor with history of jaundice that was attributed to gallstones, Rh disease, mononucleosis or in neonatal period.
51.	Chronic Liver disease or Liver Failure	Permanently defer

<b><u>HIV Infection or AIDS</u></b>		
52.	At risk for HIV infection (transgender, men who have sex with men, female sex workers, Injecting drug users, persons with multiple sex partners)	Permanently defer
53.	Known HIV positive person or spouse or partner of PLHA (person living with HIV AIDS)	Permanently defer
54.	Persons having symptoms suggestive of AIDS	Permanently defer person having lymphadenopathy, prolonged and repeated fever, prolonged & repeated diarrhoea irrespective of HIV risk or status
<b><u>Sexually Transmitted Infections</u></b>		
55	Syphilis (Genital sore, or generalised skin rashes)	Permanently defer
56.	Gonorrhoea	Permanently defer
<b><u>Other Infectious Diseases</u></b>		
57.	History of measles, mumps, chickenpox	Defer for 2 weeks following full recovery
58.	Malaria	Defer for 3 months following full recovery.
59.	Typhoid	Defer for 12 Months following full recovery
60.	Dengue or Chikungunya	In case of history of dengue or chikungunya: Defer for 6 months following full recovery. Following visit to dengue or chikungunya endemic area: 4 weeks following return from visit to dengue endemic area if no febrile illness is noted.
61.	Zika Virus or West Nile Virus	In case of Zika infection: Defer for 4 months following recovery. In case of history of travel to West Nile Virus endemic area or Zika virus outbreak zone: Defer for 4 months.
62.	Tuberculosis	Defer for 2 years following confirmation of cure
63.	Leishmaniasis	Permanently defer
64.	Leprosy	Permanently defer
<b><u>Other Infections</u></b>		
65.	Conjunctivitis	Defer for the period of illness and continuation of local medication.
66.	Osteomyelitis	Defer for 2 years following completion of treatment and cure.

<b><u>Kidney Disease</u></b>		
67.	Acute infection of kidney (pyelonephritis)	Defer for 6 months after complete recovery and last dose of medication
68.	Acute infection of bladder (cystitis) or UTI	Defer for 2 weeks after complete recovery and last dose of medication
69.	Chronic infection of kidney or kidney disease or renal failure	Permanently defer
<b><u>Digestive System</u></b>		
70.	Diarrhoea	Person having history of diarrhoea in preceding week particularly if associated with fever: Defer for 2 weeks after complete recovery and last dose of medication
71.	GI endoscopy	Defer for 12 months
72.	Acid peptic disease	Accept person with acid reflux, mild gastro-oesophageal reflux, mild hiatus hernia, gastro-oesophageal reflux disorder (GERD), hiatus hernia. Permanently defer person with stomach ulcer with symptoms or with recurrent bleeding.
<b><u>Other Diseases or Disorders</u></b>		
73.	Autoimmune disorders like Systemic lupus erythematosus, scleroderma, dermatomyositis, ankylosing spondylitis or severe rheumatoid arthritis	Permanently defer
74.	Polycythaemia Vera	Permanently defer
75.	Bleeding disorders and unexplained bleeding tendency	Permanently defer
76.	Malignancy	Permanently defer
77.	Severe allergic disorders	Permanently defer
78.	Haemoglobinopathies and red cell enzyme deficiencies with known history of haemolysis	Permanently defer
<b><u>Vaccination and Inoculation</u></b>		
79.	<b>Non-live vaccines and toxoid:</b> Typhoid, cholera, papillomavirus, influenza, meningococcal, pertussis, pneumococcal, polio injectable, diphtheria, tetanus, plague	Defer for 14 days
80.	<b>Live attenuated vaccines:</b> Polio oral, measles (rubella), mumps, yellow fever, Japanese encephalitis, influenza,	Defer for 28 days

	typhoid, cholera, hepatitis A	
81.	Anti-tetanus serum, anti-venom serum, anti-diphtheria serum and anti-gas gangrene serum	Defer for 28 days
82.	Anti-rabies vaccination following animal bite, hepatitis B immunoglobulin,	Defer for 1 year
<b><u>Medications Taken by Prospective Blood Donor</u></b>		
83.	Oral contraceptive	Accept
84.	Analgesics	Accept
85.	Vitamins	Accept
86.	Mild sedative and tranquillisers	Accept
87.	Allopurinol	Accept
88.	Cholesterol lowering medication	Accept
89.	Salicylates (aspirin), other NSAIDs	Defer for 3 days if blood is to be used for platelet preparation
90.	Ketoconazole, antihelminthic drugs including mebendazole,	Defer for 7 days after last dose if donor is well
91.	Antibiotics	Defer for 2 weeks after last dose if donor is well
92.	Ticlopidine, clopidogrel	Defer for 2 weeks after last dose
93.	Piroxicam, dipyridamole	Defer for 2 weeks after last dose
94.	Etretinate, acitretin or isotretinoin. (Used for acne)	Defer for 1 month after the last dose
95.	Finasteride used to treat benign prostatic hyperplasia	Defer for 1 month after the last dose
96.	Radioactive contrast material	8 weeks deferral
97.	Dutasteride used to treat benign prostatic hyperplasia	Defer for 6 months after the last dose
98.	Any medication of unknown nature	Defer till details are available
99.	Oral anti-diabetic drugs	Accept if there is no alteration in dose within last 4 weeks.
100.	Insulin	Permanently defer
101.	Anti-arrhythmic, anti-convulsions, anticoagulant, anti-thyroid drugs, cytotoxic drugs, cardiac failure drugs (digitalis)	Permanently defer



<b><u>Other Conditions Requiring Permanent Deferral</u></b>		
102.	Recipients of organ, stem cell and tissue transplants Donors who have had an unexplained delayed faint or delayed faint with injury or two consecutive faints following a blood donation.	Permanently defer

**9 *Counselling During Donation.***—The Counselling during donations must be aimed at.—

- (1) Ensuring that donors feel conformable during blood donation, including the venepuncture,
- (2) Reducing donor anxiety and minimising the risk of any adverse donor reactions such as fainting,
- (3) Giving post donation advice, including care of the venepuncture site,
- (4) Fostering donor trust and confidence for donor retention,
- (5) Thanking the donor for his valuable contribution.

**10 *Post-donation interaction.***—The post-donation interaction includes.—

- (1) Brief instructions on self-care:
  - (i) Plenty of fluids,
  - (ii) No heavy work,
  - (iii) No smoking or driving immediately post donation,
  - (iv) Remove bandage after 6 hours,
  - (v) Contact details of blood bank in case of discomfort following donation,
- (2) Information about what to do in case of specific adverse donor reactions,
- (3) Message on healthy lifestyle and regular blood donation,
- (4) Donor feedback,
- (5) Reiteration for recalling of blood donor for abnormal test results.

**Recall and Referral Mechanism for Sero-reactive Blood Donors**

**11. *Information of test results.***—(1) Donors who have consented to be contacted by the blood bank in case of an abnormal test result should be recalled to the blood bank so as to inform them about sero-reactive result of Transfusion Transmitted Infection.

- (2) Donors should be provided post-donation counselling prior to referring those appropriate medical services for confirmation of diagnosis, follow up and treatment whenever necessary.
- (3) Adequate efforts must be made by the Blood Bank staff to contact the initial sero-reactive blood donors for recall-referral and the process should be documented on record.

- (4) Result seeking blood donors, even if non sero-reactive, should also be informed of their Transfusion Transmitted Infection status with reiterated counselling to remain negative and continue to donate blood.
- (5) State AIDS Control Societies shall make available updated list of Integrated Counselling and Testing Centre along with contact details of counsellors to all licensed blood banks.

**12 Duties of a Blood Bank.**—(1) It is not the primary duty of the Blood Bank or Blood Transfusion Services to confirm the diagnosis of any of the Transfusion Transmitted Infection screened for.

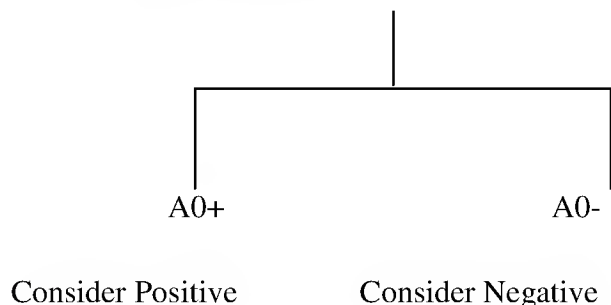
- (2) All initial sero-reactive blood units shall continue to be discarded as per standard operating protocol of blood bank and compliance to Biomedical Waste Management Rules, 2016.
- (3) Consent of the Blood Donor shall be obtained for performing the screening tests and to be informed of the results thereof at the time of blood donation.
- (4) Blood Bank shall repeat the test using the same technique using the pilot tube or sample from blood bag prior to labelling the donor as initial sero-reactive and recalling for referral.
- (5) All initial sero-reactive donors shall be recalled, offered post donation counselling and referred to appropriate facility for further counselling, confirmation and management.
- (6) Results shall not be informed over the telephone.
- (7) A standard referral format for the same shall be used and Blood Bank shall maintain all records of recall and referral.
- (8) Signatures of the blood donor shall be obtained on the consent form attached to the referral format so as to avoid litigation due to discordant results of screening at blood banks and confirmatory tests of reference centre.
- (9) In case, the initial sero-reactive donor does not return to blood bank despite three consecutive weekly attempts, the list of HIV sero-reactive blood donors should be shared with the linked Integrated Counselling and Testing Centre under shared confidentiality under guidance from State AIDS Control Society.

**13. Referral Mechanism of HIV Sero-reactive Blood Donors to Integrated Counselling and Testing Centre.**—

- (1) Testing Strategy used in the Blood Banks for HIV is “Strategy I” and the test done in the blood bank is considered to be a test of triage (A0).
- (2) The blood unit is subjected to one test of high sensitivity for HIV reactivity. If non reactive, the specimen shall be considered free of HIV (negative) and if reactive, the blood unit is considered as HIV positive and discarded. This

strategy is focused on ensuring recipient safety and is also used in the setting of screening of organs, tissues, sperm and other donations.

One test required (A0)



Flow chart of Strategy I

- (3) Prior consent shall be taken from the donor for both conduction of screening tests and to be informed of result of testing at the time of the donation by the blood bank along with complete contact details and telephone number.
- (4) All blood donors found to be HIV sero-reactive at blood bank shall be referred to Integrated Counselling and Testing Centres for counselling and confirmation.
- (5) Blood bank shall fill out the referral form as per standard format in annexure 2 and send it along with referred donor.
- (6) Confidentiality shall be maintained at all levels.

**14. Algorithm for Blood Donors Referred to Integrated Counselling and Testing Centre.—**(1) Donor shall be offered HIV pre-test counselling at the Integrated Counselling and Testing Centre and consent taken to perform the HIV test.

- (2) Integrated Counselling and Testing Centre shall perform first test. In case first test positive, Integrated Counselling and Testing Centre shall perform remaining two tests and give a positive result after three sequential reactive tests.
- (3) In case first test is negative, Integrated Counselling and Testing Centre shall report the result as Human Immunodeficiency Virus inconclusive and recall the donor for re-testing after two weeks.
- (4) All blood donors found to be positive for HIV shall be counselled to permanently defer them from the donor pool, in addition to referral for Pre-ART during post-test counselling.

- (5) In addition, the message for all People Living with AIDS to permanently defer themselves or spouses or partners from donating blood shall be incorporated into the information for all People Living with AIDS during post-test counselling.

**15. Referral Mechanism of other Transfusion Transmitted Infection Sero-reactive Blood Donors to Clinicians.—**

(1) The blood unit is subjected to one test of high sensitivity for Hepatitis B Virus, Hepatitis C Virus, Malaria and syphilis reactivity. If non-reactive, the specimen is to be considered free of infection (negative) and if reactive, the blood unit is considered as positive and discarded. This strategy is focused on ensuring recipient safety and is also used in the setting of screening of organs, tissues, sperm and other donations.

- (2) Prior consent shall be taken from the donor for both conduction of screening tests and to be informed of result of testing at the time of the donation by the blood bank along with complete contact details and telephone number.
- (3) All blood donors found to be sero-reactive at blood bank for HBV, HCV, Syphilis and Malaria shall be referred to clinicians in the Out Patient Department of associated hospitals or others for assessment and re-testing.
- (4) Blood bank shall fill out the referral form as per standard format in Annexure 2 and send it along with referred donor.
- (5) Confidentiality shall be maintained at all levels.

**16. Algorithm for Blood Donors Referred to Clinicians.—**(1) Donor shall be assessed by the clinician with history taking and clinical examination.

- (2) Donor shall be referred to the laboratory for re-testing and confirmation of the test results.
- (3) Donor shall be offered appropriate treatment by the assessing clinician or referred to a higher centre for the same.
- (4) All blood donors found to be positive for HBV, HCV, Malaria and Syphilis should be counselled to defer themselves and their spouses or partners from the donor pool, in addition to appropriate management.

**Annexure 1****Sample of Blood Donor Questionnaire****XYZ Blood Bank***Thank you for coming forward to donate blood*

To ensure your safety as a blood donor and the safety of the patients who will receive your blood, please read the information leaflet provided and answer this questionnaire correctly. If you have any difficulty in filling this form please ask for help from the Blood Centre Staff. All details given by you will be kept confidential.

Donor's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address (Resi.): \_\_\_\_\_

\_\_\_\_\_

	Sex:
	Age:

Address (Office) \_\_\_\_\_

\_\_\_\_\_

Contact Nos : (Resi.) \_\_\_\_\_ (Office) \_\_\_\_\_ (Mobile) \_\_\_\_\_

E-Mail \_\_\_\_\_

1. Have you donated Blood previously? Yes      No
- 1.1. If yes how many times 1.2 Date of last donation:
- 1.3. Did you experience any ailment, difficulty or discomfort during previous donations?
- 1.4. What was the difficulty?
- 1.5. Have you ever been advised not to donate blood? Yes      No
- 2.1. Are you feeling well today?
- 2.2. Have you eaten anything in the last 4 hours?
- 2.3. After donating blood do you have to engage in heavy work, driving heavy vehicle or work at heights today Yes      No



3. Have you had / have any of the following? If yes, discuss with the doctor present:

- |                    |                  |                             |                             |
|--------------------|------------------|-----------------------------|-----------------------------|
| • Allergy          | • Kidney disease | • Endocrine disease         | • Leprosy                   |
| • Cancer           | • Mental illness | • Diabetes                  | • Epilepsy                  |
| • Fainting attacks | • Amoebiasis     | • Syphilis                  | • Blood / Bleeding disorder |
| • Heart disease    | • Cold / cough   | • Gonorrhoea                | • Tuberculosis              |
| • Lung disease     | • Liver disease  | • Skin disease              | • Polycythemia              |
| • Asthma           | • Fever          | • High / Low Blood Pressure | • G – 6 PD deficiency       |

4. During past 12 months have you had any of the following?

- |   |     |    |
|---|-----|----|
| 4.1. Received blood or blood components?                    | Yes | No |
| 4.2. Any accidents or operations                            | Yes | No |
| 4.3. Received any vaccinations                              | Yes | No |
| 4.4. Bitten by any animal, which can result in rabies?      | Yes | No |
| 4.5. Had tattooing / ear piercing or acupuncture treatment? | Yes | No |
| 4.6. Have you been imprisoned for any reason?               | Yes | No |

5. Have you had jaundice in the last 1 year?

Yes No

5.1. Has your blood ever tested positive for hepatitis B or C?

Yes No

5.2. Have you had close contact with anyone (family / others) suffering from jaundice in the last 1 year?

Yes No

6. Have you had tuberculosis or typhoid during the last year?

Yes No

7. Have you had malaria or taken antimalarial drugs in the last 3 years?

Yes No

8. Have you had any of the following in the last 6 months?

Dental Procedure

Yes No

Measles

Yes No

Mumps

Yes No

Chicken Pox

Yes No

Dengue

Yes No

9. Have you taken any medicine in the last 7 days especially or antibiotic

Yes No

10. Do you know that you should not give blood in following conditions?

Yes No

- If you were found to be HIV positive, Hepatitis B, C or Syphilis infections
- If you are having multiple sex partners or have engaged in male to male sexual activity
- If you have ever worked as a sex worker or had sex with a sex worker
- If you have ever injected any drug (esp. Narcotics) not prescribed by a qualified doctor
- If you suspect that you or your partner may have HIV or any other sexually transmitted disease

**11. Do you or your sexual partner belong to one of the above or below categories? Yes No**

- |  |     |    |
|--|-----|----|
| 11.1. Do you have any reason to believe that you have been infected by the virus that causes AIDS? | Yes | No |
| 11.2. In the last 6 months have you had:   |     |    |
| Night sweats   | Yes | No |
| Persistent fever   | Yes | No |
| Unexplained Weight Loss  | Yes | No |
| Swollen Glands   | Yes | No |
| Persistent diarrhea  | Yes | No |

**12. In case you are a woman:**

- |   |     |    |
|---|-----|----|
| a. Are you pregnant or have you had an abortion in the last 6 months? | Yes | No |
| b. Have you a child less than 1 year of age? Are you breast feeding?  | Yes | No |

**Consent**

*I understand that:*

- (a) Blood donation is a totally voluntary act and no inducement or remuneration has been offered
- (b) Donation of blood/components is a medical procedure and that by donating Voluntarily, I accept the risk associated with this procedure.
- (c) My donated blood, blood and plasma recovered from my donated blood may be sent for plasma fractionation for preparation of plasma derived medicinal products, all of which may be used for larger patient population and not just this blood bank.
- (d) My blood will be tested for Hepatitis B, Hepatitis C, Malaria parasite, HIV/AIDs and syphilis diseases in addition to any other screening tests required ensuring blood safety.
- (e) I would like to be informed about any abnormal test results done on my donated blood: Yes/No

Donor's Signature:

(Name .....)

Signature of Medical Officer:

(Name .....)

MEDICAL ASSESSMENT	Name of Medical Officer:	Sign:
Donor's Name:_____		
Weight:_____ kgs Hb Level: $\geq 12.5\text{g/dl}$ $<12.5\text{g/dl}$		
History Check list	Feeling well / Adequate sleep (>5hrs) / Last meal within 4 hrs Ever hospitalized Current illnesses or medications:	
Examination Check List	Unhealthy look / pallor / icterus / alcohol smell Infected wounds / Venepuncture site lesions Pulse:.....beats/min BP:.....mmHg Heart:..... Lungs:.....	
Counseling Points	Post donation instructions / making a regular donor Need for follow up for TTI purposes. How to contact for follow up purposes: By a letter / By phone / By e-mail	
Outcome	Donor accepted / Temporary deferral / Permanent deferral	
Remarks / Reasons for Deferral:		

REGISTRATION	Name of Medical Officer:	Date
Donor I.D. No.	Blood Unit No.	Segment No:
Type of Bag: Single. Double.: Triple.: Quadruple.:		

BLOOD COLLECTION	Name of Phlebotomist:	Sign:
Check: Donor's Name		
Check Donation No: On Donation record / Blood Bags / Specimen Tubes		
Start time:..... a.m. / p.m. Time Taken:.....mins.		
Volume:.....ml		
Complications: Faint: Fits: Double Prick: Haematoma: Others (please specify):		
Management:		

**Annexure 2****REFERRAL SLIP FOR BLOOD DONORS***(To be filled by Blood Bank Staff)*

Name and address of the Referring Blood Bank: -

Date of Referral ..... Blood Bank ID No. ....

Name of Donor.....

Age ..... Gender ..... Phone Number ..... Contact details.....

Name and designation of the referring person .....

Reason for referral (to be ticked)	Date of testing	Assay used (III gen or Any other)
Counselling& testing for HIV <input type="checkbox"/>		
Testing of HBs Ag <input type="checkbox"/>		
Testing of HCV <input type="checkbox"/>		
Testing of VDRL or RPR <input type="checkbox"/>		
Testing of Malaria <input type="checkbox"/>		

Address of referral centre (ICTC or Clinician).....

(Blood Bank seal with contact details)

*(To be filled by ICTC or Laboratory and retained in record)*

Name of Donor.....Date of performing test.....

PID No. or OPD Regn. No. ....

Investigation done .....

Results .....

(Seal of ICTC or Laboratory with contact details)

-----X-----X-----X-----X-----X-----X-----

*(This part is to be filled by ICTC or Laboratory and returned to donor)*

Name of the Donor or Department .....

Donor ID No. .... PID No or OPD Regn. No. ....

Date of Sample draw.....

Instructions:

Please come for retesting after 2 weeks on

1. Result to be collected on.....

2. Repeat test at ICTC on .....

(Seal of ICTC or Laboratory with contact details).

(F.M. : .....) )

Sd/-

Designation

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 682 .**—मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 की उप-धारा (1) उपबंध करती है कि केन्द्रीय सरकार सामान्यतः उक्त अधिनियम के उपबंधों को कार्यान्वित करने हेतु, उक्त अधिनियम और उसके अधीन बनाए गए नियमों से संगत मार्गदर्शन बना सकेगी;

और उक्त धारा की उप-धारा(2), अन्य बातों के साथ-साथ, केन्द्रीय सरकार को राष्ट्रीय एड्स नियंत्रण परियोजना के अधीन ओपिऑएड प्रतिस्थापन चिकित्सा, बूप्रेनॉर्फाइन के साथ उपचारार्थ चिकित्सीय पद्धति मार्गदर्शन के प्रयोजनार्थ बनाने के लिए सशक्त करती है;

अतः, अब, केन्द्रीय सरकार मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए इस अधिसूचना से उपाबद्ध अनुसूची के अनुसार "बूप्रेनॉर्फाइन के साथ उपचारार्थ चिकित्सीय पद्धति मार्गदर्शन (राष्ट्रीय एड्स नियंत्रण कार्यक्रम के अधीन ओपिऑएड प्रतिस्थापन चिकित्सा)", 2018 अधिसूचित करती है।

[फा. सं. टी-11020/50/1999-नाको (पी एंड सी)]

आलोक सक्सेना, संयुक्त सचिव

New Delhi, the 14th August, 2020

**S.O. 682 .**—Whereas sub-section (1) of section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017) provides that the Central Government may make guidelines consistent with the said Act and any rules made there under, generally to carry out the provisions of the said Act;

And whereas sub-section (2) of the said section, *inter alia*, empowers the Central Government to make guidelines for the purposes of Opioid Substitution Therapy Under National AIDS Control Programme, Clinical Practice Guidelines for Treatment with Buprenorphine;

Now, therefore, in exercise of the powers conferred by section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017), the Central Government hereby notifies the "Clinical Practice Guidelines for Treatment with Buprenorphine (Opioid Substitution Therapy Under National AIDS Control Programme), 2018" as per the Schedule annexed to this notification.

[F. No. T-11020/50/1999-NACO(P&C)]

ALOK SAXENA, Jt. Secy.

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**SCHEDULE****“Clinical Practice Guidelines  
for Treatment with Buprenorphine”****(Opioid Substitution Therapy Under  
National AIDS Control Programme), 2018**

PUBLIC  
HEALTH  
FOUNDATION  
OF INDIA

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डॉ. वि. के. सुब्बुराज, आ.प्र.सं.  
सचिव  
Dr. V.K. SUBBURAJ, IAS  
Secretary



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
एड्स नियंत्रण विभाग  
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National AIDS Control Organisation  
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### Message

India has made significant achievements in containing Human Immunodeficiency Virus (HIV) infection. India is one of the few countries across the globe that has been able to bring about reduction in the incidence of HIV in the country. Additionally, HIV prevalence among certain high risk groups such as female sex workers has also been reduced. This has been possible due to massive efforts from all the stakeholders concerned, including the civil society, affected communities, technical experts, as well as the various divisions working within the Department of AIDS Control (DAC).

While there is much to celebrate, certain high risk groups continue to show high prevalence of HIV. Injecting Drug Users (IDUs) is one such group that has more than 5% HIV prevalence consistently across various rounds of sentinel surveillance. Efforts have been made in the third phase of the National AIDS Control Programme (NACP) to scale up HIV prevention services for Injecting Drug Users, mainly with respect to Needle Syringe Programmes. There are more than 280 targeted interventions (TIs) working exclusively for Injecting Drug Users, covering more than 80% of the Injecting Drug Users population in the country. Opioid Substitution Therapy (OST) is another important element of HIV prevention among Injecting Drug Users. The process of initiating Opioid Substitution Therapy within the HIV programme began during National AIDS Control Programme III, and a number of quality assurance mechanisms were built in the programme. Newer models of Opioid Substitution Therapy delivery were also tested and found to be equally feasible. There are currently about 150 Opioid Substitution Therapy centres in the country catering to about 15000 Injecting Drug Users.

Opioid Substitution Therapy remains an important intervention strategy in the National AIDS Control Programme IV, and Department of AIDS Control is committed to scale up the Opioid Substitution Therapy intervention, so that a greater number of Injecting Drug Users would benefit from this intervention strategy. The revised clinical practice guidelines document is in tune with this commitment. I am given to understand that the experience accumulated so far in Opioid Substitution Therapy implementation under National AIDS Control Programme has been made use of to modify the document. I am sure that this revised guideline from Department of AIDS Control would help the service providers to provide optimum care and treatment for the Injecting Drug Users. I wish the stakeholders all the best for their endeavours.

*V. K. Subburaj* 28/7/2014

Secretary

Department of AIDS Control



## Preface

The present document is a revision of the document “Substitution Therapy with Buprenorphine for Opioid Injecting Drug Users – Practice Guidelines” that was developed by the National AIDS Control Organisation in 2008 for guiding the implementation of National AIDS Control Organisation supported Opioid Substitution Therapy (OST) programmes in India. The current revision of the document has been made taking into consideration a number of developments. Opioid Substitution Therapy programme in India has progressed to a great extent through National AIDS Control Programme (NACP) since 2008. The National AIDS Control Organisation Opioid Substitution Therapy programme was in its nascent stages in 2008, with handful of centres as well as limited capacities to implement Opioid Substitution Therapy services. Today, the OST programme is functional in at least 150 centres, and National AIDS Control Organisation Opioid Substitution Therapy has more than six years of experience in supporting the training, monitoring and supervision of these centres. Apart from initial trainings conducted, a number of other activities such as refresher trainings, quality assurance visits, accreditation and supervisory visits by National AIDS Control Organisation officers have been conducted. This has led to a deeper understanding of the problems faced by the service providers in the day-to-day implementation of Opioid Substitution Therapy programme. The existing document was found inadequate to guide the service providers, especially the clinical staff working in Opioid Substitution Therapy centres, which form the backbone of the intervention implementation.

There have been a number of changes made in the document. A detailed background section is now provided that provides a conceptual understanding of the need for Opioid Substitution Therapy for injecting drug users (IDUs). The section on clinical practices has been expanded and the specific goal, objectives and practices thereof for the particular stage of the Opioid Substitution Therapy implementation has been added. Finally, the section on special clinical situation has been introduced for the first time that deals in detail with day-to-day problems encountered by clinicians in Opioid Substitution Therapy implementation. Special issues such as adolescence and pregnancy have been dealt with in greater detail.

The primary audience for the document remains the medical and paramedical staff working in the National AIDS Control Organisation-supported Opioid Substitution Therapy centres. However, the writing style has been kept simple so that even other staff can benefit from the document. It is hoped that the document helps in improving the quality of Opioid Substitution Therapy interventions in the country. The authors are thankful to the reviewers for providing feedback on the document. Special thanks also to National AIDS Control Organisation Targeted Intervention division for their encouragement and feedback on the document. Finally, thanks are also due to the various Opioid Substitution Therapy centre staff as well as the service recipients who have provided greater understanding of the Opioid Substitution Therapy programme that has made this revision possible.

Ravindra Rao

Alok Agrawal

Atul Ambekar

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# Abbreviations

ANM	Auxiliary Nurse Midwifery
ART	Anti-Retroviral Treatment
CHC	Community Health Centre
DAC	Department of AIDS Control
DIC	Drop-in Centre
DOTS	Daily Observed Treatment Strategy
HIV	Human Immunodeficiency Virus
HRGs	High Risk Groups
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Use
NACP	National AIDS Control Programme
NAS	Neonatal Abstinence Syndrome
NDPS	Narcotic Drugs and Psychotropic Substances
NGOs	Non-Governmental Organisations
NSP	Needle Syringe Programme
ODS	Opioid Dependence Syndrome
OST	Opioid Substitution Therapy
PHC	Primary Health Centre
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
UNAIDS	Joint UN Programme on HIV or AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

# Introduction

It is estimated that there are 177000 Injecting Drug Users in India. The distribution of Injecting Drug Use (IDU) population is not uniform throughout the country. As of 2014, there are some states that have high number of Injecting Drug Users (IDUs) including, Manipur, Nagaland, Punjab, Mizoram and Delhi. Injecting Drug User is an important factor in the transmission dynamics of HIV epidemic in India. HIV in India is a concentrated epidemic – concentrated in certain geographical areas and among certain population groups. These population groups, designated as High Risk Groups (HRGs), have much higher prevalence of HIV as compared to the general population. As per the latest HIV sentinel surveillance report, HIV prevalence among Injecting Drug Users is 7.2% nationally, which is one of the highest among any population group. However, some states have much higher HIV rates among Injecting Drug Users; for e.g. HIV prevalence among Injecting Drug Users is 21% in Punjab, 18% in Delhi and around 12% in Manipur and Mizoram.

Thus, there is considerable variability among Injecting Drug Users in terms of their numbers, their choice of drugs for injecting, their socio-demographic characteristics, and HIV prevalence among the group.

**A. NATIONAL STRATEGY FOR HIV PREVENTION AMONG INJECTING DRUG USER POPULATION.**—Globally, the “harm reduction” strategy is employed to manage HIV prevention among Injecting Drug Users. Harm reduction strategy is based on the premises that it is as important to focus on addressing harms associated with drug use as it is to help them give it up. The strategy offers an effective alternative approach for continuous engagement and HIV prevention among drug users, especially those who are unable or unwilling to give up drug use through other abstinence-oriented approaches. Priority is accorded to immediate, easily preventable harms of

## COMPREHENSIVE PACKAGE OF INTERVENTIONS:

1. Needle Syringe Programmes.
2. Opioid Substitution Therapy.
3. Anti-retroviral Therapy.
4. Counselling and Testing for HIV.
5. Prevention and Treatment for Sexually Transmitted Infections (STIs).
6. Condom programme for Injecting Drug Users and their partners.
7. Targeted Information, Education and Communication.
8. Prevention, Diagnosis and Treatment of Tuberculosis.
9. Prevention, Diagnosis and Treatment of Viral Hepatitis.

public health importance. HIV prevention becomes an important focus of harm reduction. A number of interventions have been found to be useful and effective for HIV prevention among Injecting Drug Users. World Health Organisation, Joint UN Programme on HIV or AIDS and United Nations Office on Drugs and Crime, together, have proposed nine interventions for HIV prevention, care and treatment of Injecting Drug Users which, when implemented together, are called the “comprehensive package of interventions” for HIV prevention among Injecting Drug Users. The core interventions among these include – Needle Syringe Programme (NSP), Opioid Substitution Therapy (OST), and Anti-Retroviral Treatment (ART).

In India, the harm reduction strategy is endorsed in the National AIDS Prevention and Control Policy (NAPCP), 2002. Department of AIDS Control (DAC) is the nodal agency responsible for HIV prevention, care and treatment in India. Department of AIDS Control follows a ‘targeted intervention (TI)’

approach for HIV prevention among all High Risk Groups, including Injecting Drug Users. The targeted intervention approach entails providing interventions specifically aimed at High Risk Groups through outreach and peer-based delivery. In the 'outreach' model, services are delivered at places where the High Risk Groups are most likely to be found, using their own peers as primary agents of service delivery (peer-based service delivery). The Targeted Intervention projects are implemented by Non-Governmental Organisations (NGOs) who are able to reach out to High Risk Group much more efficiently as compared to the traditional service delivery systems. For HIV prevention among Injecting Drug Users, the targeted intervention-based services include – Needle Syringe Programme, condom distribution, abscess prevention and management, general medical care, Sexually Transmitted Infection prevention and treatment, and behaviour change communication. Additionally, testing for HIV, Antiretroviral Therapy, Tuberculosis diagnosis and treatment, as well as drug treatment services are provided through referral linkages to the concerned service provider.

As in 2014, there are more than 280 core Injecting Drug Users Targeted Interventions throughout the country, reaching out to about 152000 Injecting Drug Users, which is more than 80% of the Injecting Drug User population in the country. Thus, there is a saturation of the coverage of Injecting Drug Users with HIV prevention services in India. Programmatic data also shows that there has been a significant increase in commodity distribution, number of needle or syringes distributed per Injecting Drug User, referrals for HIV testing, etc.

**B. OPIOID SUBSTITUTION THERAPY UNDER NATIONAL AIDS CONTROL PROGRAMME.—** Opioid Substitution Therapy as a HIV prevention strategy among Injecting Drug Users was formally integrated in National AIDS Control Programme (NACP) in 2007, during its third phase. Before formal integration, Opioid Substitution Therapy for HIV prevention among Injecting Drug Users was being implemented in India by some Non-Governmental Organisations. After a formal approval for Opioid Substitution Therapy implementation, besides putting in place mechanisms for financial support to the Non-Governmental Organisations

implementing Targeted Intervention projects, a number of documents for standardisation and quality assurance have been developed by Department of AIDS Control, *including practice guidelines for buprenorphine, standard operating procedures and quality assurance manual*. The Non-Governmental Organisation Opioid Substitution Therapy centres were also accredited through an independent accreditation agency, following which they started receiving support through Department of AIDS Control. In this Non-Governmental Organisations-based model of Opioid Substitution Therapy, the Opioid Substitution Therapy centres located within the Drop-in-Centre (DIC) of an Injecting Drug User Targeted Intervention are managed by the staff implementing the Injecting Drug User Targeted Intervention. A part-time doctor, a full-time nurse, a counsellor or Auxiliary Nurse Midwifery, programme manager and outreach workers are part of the team delivering Opioid Substitution Therapy services.

To further expand the Opioid Substitution Therapy programme, since 2010, Government hospitals have also been roped in for providing Opioid Substitution Therapy services through a collaborative public health model. In this model, the Opioid Substitution Therapy centre is located within the government hospital and is manned by a full-time staff comprising of a doctor, a nurse, a counsellor and a data manager. The staff of the Opioid Substitution Therapy centre works under the direct supervision of a designated 'nodal officer', who is a full-time employee of the hospital. The Opioid Substitution Therapy centre is linked with an Injecting Drug Users Targeted Intervention located in the vicinity of the hospital for initial referral of Injecting Drug Users clients to the centre, as well as field-based follow-up and advocacy. Currently, there are about 150 Opioid Substitution Therapy centres in the country supported by Department of AIDS Control, operating through either the Non-Governmental Organisation or the collaborative public health model, catering to about 15000 Injecting Drug Users. There is a plan to establish about 350 Opioid Substitution Therapy centres and increase the Opioid Substitution Therapy coverage to 35000–40000 Injecting Drug Users during National AIDS Control Programme IV.

## **About the document...**

1. The clinical practice guidelines are intended to be used by the staff implementing Opioid Substitution Therapy interventions supported under the National AIDS Control Programme.
2. This edition of the Clinical Practice Guidelines supercedes the earlier edition, published in 2008.
3. While all staff members (including those of linked Injecting Drug User Targeted Interventions) would be benefitted, these guidelines are especially relevant for doctors and counsellors working in these centres. The guidelines aim to provide guidance mainly on the clinical practices related to Opioid Substitution Therapy implementation supported by Department of AIDS Control.
4. These guidelines are not a substitute to formal training programmes, which each staff is expected to undergo. The guidelines are complementary to the “standard operating procedures” for Opioid Substitution Therapy implementation approved by Department of AIDS Control.
5. For preparing the document, the authors have heavily relied upon scientific evidence-base, especially from India, other similar guidelines published for India, the training manuals and operational procedures developed for Opioid Substitution Therapy, as well as their own clinical and programmatic experience.

# Background



## Understanding Injecting Drug Use and Injecting Drug Users

**A. DEFINITION OF 'INJECTING DRUG USER.'**— Different definitions have been used for identifying who is an Injecting Drug User. Some researchers opine that a person who has injected even once in his or her lifetime is an Injecting Drug User, while others define an Injecting Drug User as someone who has injected atleast once in the past 12 months. In India, for programmatic purposes, **Department of AIDS Control defines an Injecting Drug User as a person 'who has used any psychoactive substance through injecting route for non-medical purpose at least once in the last three months.'** This definition is based upon the recommendation of experts working in the field of Injecting Drug User in India.

**B. DRUGS INJECTED BY INJECTING DRUG USERS IN INDIA.**— Though theoretically, as per the definition, an Injecting Drug User may use any psychoactive substance through injecting route, research conducted thus far has shown that in India, **a vast majority of the Injecting Drug Users use opioids as their primary drug of choice.** These opioids include heroin (pure or the impure – 'smack' or 'brown sugar') as well as pharmaceutical opioids such as buprenorphine, pentazocine and dextro-propoxyphene. The opioids may be injected either alone or in combination with other substances which include benzodiazepines such as diazepam, or antihistamines such as chlorpheniramine<sup>1</sup> or promethazine. The other substances are combined with opioids to enhance the pleasure of opioids or due to some perceptions existing among Injecting Drug Users regarding their positive effects.

**OPIOIDS.**— Opioids are a group of psychoactive substances that are similar in action to that of opium poppy. Opium is a plant product, extracted from the plant *Papaver Somniferum*.

Opioids act specifically on a set of receptors in humans, named as opioid receptors. Some of the common opioids include:

- (i) **Natural derivatives:** Morphine, Codeine.
- (ii) **Semi-synthetic:** Buprenorphine, Heroin.
- (iii) **Synthetic:** Methadone, Dextropropoxyphene, Pentazocine.



**The opioids used for injection in India are: Heroin ("No. 4"), "Smack" (impure heroin), buprenorphine, dextropropoxyphene and pentazocine.**

The choice of opioids for the purpose of injecting differs from one region to another. In the north-eastern region, heroin and dextropropoxyphene are the most commonly used opioids; impure heroin, known as "smack", and buprenorphine are the most commonly used opioids in metropolitan cities such as Delhi, Mumbai, Chennai and Kolkata. In states such as Karnataka, Andhra Pradesh, Chhattisgarh, etc., pentazocine is the most commonly injected opioid. In the states of Punjab and Haryana, buprenorphine is the choice of opioid injectors. Thus, the opioids injected are either heroin or its impure variety, that is manufactured and sold illegally only for the purpose of abuse, or pharmaceutical opioids (such as buprenorphine, dextropropoxyphene and pentazocine) which are also manufactured and sold in pharmacies or chemist shops due to their medicinal value.

**C. SUBSTANCE USE DISORDERS.**— It must be remembered that the mere presence of behaviour of 'injecting drug use' does not qualify for a diagnosis of substance use disorder. The pattern of drug use of an individual must be dysfunctional enough to warrant a medical diagnosis for which a treatment needs to be advised. Under the International Classification of Diseases – 10th revision (ICD-10), given by the World Health Organisation (WHO), two distinct diagnostic entities exist, as below:

- (i) **Harmful use.**— A pattern of substance use, in which a user experiences physical or psychological harms by substance use, and despite such harms, continues to use the substance.

During harmful use, though the user is not dependent on the particular substance, he or she still suffers from adverse consequences related to the use of the substance and continues the substance even though he or she experiences these harms. The user may or may not be using the substance on a daily basis.

- (ii) **Dependence.**—This is a pattern of substance use in which the substance is used on a daily or almost daily basis, and the substance use and associated behaviour takes precedence over other behaviours or activities that were important to the individual. In this pattern of substance use, a number of symptoms generally appear in the physical, psychological and social domains that form the diagnostic criteria of dependence.

**DEPENDENCE SYNDROME.**— For making a diagnosis of dependence syndrome for a given substance, the following criteria should be fulfilled for at least three months in a one-year period:

- a) Use of substance in high amounts over a long period of time.
- b) Need to increase the quantity of substance to get the same pleasure (tolerance).
- c) Appearance of specific physical and or psychological symptoms upon stopping or reducing the amount or use of substance (withdrawal symptoms).
- d) Intense desire to consume the substance (craving).
- e) Continued use of the substance despite harm.
- f) Significant socio-occupational dysfunction due to substance use.
- g) Significant time spent in procuring or using or recovering from the substance in a day.

(Adapted from ICD-10 guidelines)

The withdrawal symptoms differ from one chemical class of substance to another. Thus, for example, a typical withdrawal syndrome for any alcoholic beverage (whisky, vodka, gin, beer, wine, rum, etc.) would be sleeplessness, anxiety, restlessness, tremors, palpitations, etc. On the other hand, stimulant withdrawals may produce excessive sleep, lethargy, irritability, sadness, etc. A typical feature of withdrawal syndromes is that they tend to immediately subside once the individual re-starts using the same (or similar) substance. Thus, an alcohol dependent person experiencing withdrawal would start feeling better after drinking and an opioid dependent person would feel relieved after taking the next dose of opioids.

In case of use of more than one substance simultaneously, it is not necessary for the user to be dependent on all the substances; he or she may be dependent on one substance, while he or she may have harmful use of another substance. For e.g., an individual using opioids as well as alcohol may be dependent on opioids, while he may be using alcohol in a 'harmful use' pattern.

Usually, an individual progresses from the stage of use and harmful use before going on to develop dependence on the substance in question. As stated earlier, the stages of 'harmful use' and 'dependence' are clearly morbid and are diagnostic entities. The time taken to progress from one stage to another is different for different persons and substances consumed. For example, an opioid user usually progresses rapidly within weeks from first use to dependence.



**D. OPIOID DEPENDENCE SYNDROME.**—Opioid dependence syndrome (ODS) is a pattern of opioid drug use in which an individual uses opioids on a daily or almost daily basis and fulfils the criteria for dependence on opioid drugs. Some features of opioid dependence syndrome are as follows:

- (i) **Acute withdrawals.**—Opioids as a group produce typical physical withdrawal syndrome on a short term basis, upon reducing or stopping or even delaying the intake of the usual amount of opioid drugs. These withdrawal symptoms include *lacrimation* (tears from the eyes), *rhinorrhoea* (running nose), *yawning*, *diarrhoea*, *muscle cramps*, *sweating*, *muscle aches and pains*, etc. Along with these symptoms, othersymptoms include *anxiety*, *restlessness*, *insomnia*

(not able to sleep), *irritability*, as well as an *intense urge* (craving) to consume opioids. These 'acute' withdrawal symptoms are usually self-limiting in nature, i.e., they usually rise up to a peak level and subsequently subside on their own even without any intervention or help. However, these acute withdrawal symptoms are very distressing and disabling for the client, and often a cause for the client to restart or continue his or her opioid use. In most of the cases, once opioid use has stopped, the acute withdrawal symptoms would last for about two to three weeks before subsiding, provided the user has not resumed using opioid drugs.

- (ii) **Protracted withdrawals.**—In most clients, even after the acute withdrawals have been resolved, some symptoms may persist for a longer period of time, i.e. up to four to six months. These include: mild aches and pains, loss of interest in pleasurable activities, pre-mature ejaculation, sleep disturbances, and craving. These symptoms are also some reasons for relapse in a number of opioid users.
- (iii) **Relapsing nature of illness.**—As is true of other substance use disorders, especially dependence syndromes, Opioid Dependence Syndrome is also characterized by repeated relapses and remissions. An individual may restart using opioids after a period of abstinence. Such relapses and remissions are a feature of Opioid Dependence Syndrome especially among those who have used them for prolonged periods (years).
- (iv) **High risk behaviours.**—Opioid use may be associated with various behaviours associated with high risk of transmission of blood-borne viruses such as HIV. As discussed above, opioids can be used through an injecting route, and a number of Injecting Drug Users resort to sharing of needles or syringes or other injecting equipment. Injecting is a very efficient means of transmission of blood borne viruses, including HIV, hepatitis B and C, as a result of which HIV prevalence among Injecting Drug Users is very high. Additionally, individual users may also have high risk sex behaviours resulting in transmission of HIV through the sexual route to their female partners and the sex workers.
- (v) **Multiple harms.**—An opioid dependent user may incur harms in multiple domains of life. There may be family complications in terms of broken families, family fights, domestic violence, etc.; legal complications may include involvement in illegal activities like stealing, drug peddling, petty thefts, and incarceration, etc.; social complications may include loss of reputation or social status, being a social outcast, ridicule from society, sometimes even inhuman treatment or physical torture.

#### **E. INJECTING DRUG USERS – RISK AND VULNERABILITY.—**

- (i) **Injecting-related risky behaviours.**—Injecting Drug Users are vulnerable to sharing of needles, syringes and other injecting paraphernalia. The sharing related behaviour may be due to a number of factors, such as non-availability of needles or syringes, non-affordability of needles or syringes or due to prevalent practices in group or peer norms, etc. Apart from sharing, there may be reuse of needles or syringes. These behaviours lead to a number of complications including abscesses, blocked veins, and transmission of blood-borne viruses such as hepatitis C, B and HIV.
- (ii) **Sex-related risky behaviours.**—Injecting Drug Users also engage in high risk sex behaviours including sex with female sex workers, sex without condoms, and sex with multiple partners. They may also sell sex in exchange for drugs or money. These behaviours put Injecting Drug Users at risk for acquiring and transmitting HIV as well as other sexually transmitted infections to not just other injecting drug users but also to the general population.
- (iii) **Drug-related vulnerabilities.**—As mentioned above, almost all Injecting Drug Users in India use opioids as the primary drugs for injecting; studies also show that **almost all IDUs are opioid dependent**. In dependence syndrome, the use of drugs and injecting does not remain a matter of choice for the user; drug use becomes a compulsion – in the absence of drug use, the user suffers from withdrawal symptoms that compel him or her to continue or restart the use of drugs. As a result, the Injecting Drug Users suffer from harms resulting from opioid dependence in addition to the above-mentioned injecting and sex-related risks. An additional vulnerability of concern among Injecting Drug Users is of 'overdose'. If a person takes a heavier dose of drugs than he is accustomed to, this may result in serious intoxication and overdose, which is a potentially fatal, medical emergency.



## **Opioid Substitution Therapy– Basic Concepts and Principles**

Various terminologies have been used to describe the clinical practice of maintaining opioid dependent drug users on opioid medicines over a long period of time. These include—oral substitution treatment, opioid substitution treatment, oral substitution—buprenorphine, medication assisted treatment, buprenorphine maintenance treatment, methadone maintenance treatment, etc. All these terminologies describe the same practice. Under the National AIDS Control Programme, the term 'Opioid Substitution Therapy' (OST) is currently in use.

Opioid Substitution Therapy is a process in which opioid-dependent injecting drug users are provided with long acting opioid agonist medications for a long period of time under medical supervision along with psychosocial interventions. Short-term treatment of opioid dependence lasting for a couple of weeks called 'detoxification' which involves management of acute withdrawals alone, is associated with very high rates of relapse. Long-term treatment is hence necessary for opioid dependence. Opioid Substitution Therapy is one such long-term treatment option.

The lives of Injecting Drug Users revolve around illicit opioid use. Most of their day is spent in procuring the drugs, using them or recovering from the effects of the drugs. Withdrawals and craving associated with opioid use compel them to consume opioids repeatedly. As the opioid drugs usually have short-term effects, the drug using population needs to inject them multiple times throughout the day. As a result, they are not able to concentrate on other aspects of their life, including their work, family and social roles or responsibilities. They are also forced to indulge in illicit activities to finance their drug use. Opioid Substitution Therapy addresses a number of such issues faced by the Injecting Drug User clients:

1. **The opioid medicines used for Opioid Substitution Therapy relieve drug-related withdrawals and craving and do not lead (when used in appropriate doses) to acute intoxication**(which is seen with use of illicit opioids). Thus, the client is maintained in a state which produces neither intoxication nor withdrawals, nor craving. Due to this, the client does not need to use opioids to produce relief of withdrawals or craving.
2. As compared to the illicit opioids that act quickly and for a short period of time, **opioid medicines used for Opioid Substitution Therapy act slowly and for a long period of time (for at least 24 hours)**. As a result, the client does not have to spend time on procuring or using opioids frequently in a given day and can focus on other important activities like occupational and family responsibilities.
3. The illicit opioids used by the clients are taken by routes that are potentially harmful. Many harmful effects faced by Injecting Drug Users are due to the injecting route of administration. On the other hand, opioid medicines used for **Opioid Substitution Therapy are administered orally or sublingually, which is a much safer route**. This saves the client from incurring harmful effects of opioid use.
4. As the Injecting Drug Users procure the opioids mostly through illegal channels, they are often not aware of the purity of the opioid product they inject. This is especially true for heroin and its impure form, "smack". The purity of street heroin varies across different time periods as well as across the drug suppliers. This may result in life-threatening overdose situations if the heroin is purer than usual. On the other hand, the **potency and purity of opioid medicines used for Opioid Substitution Therapy is known**; this helps in averting overdose situations.
5. As the street opioid drugs are costly, Injecting Drug Users often resort to illegal activities to finance their drug use. However, as the opioid medicines used for Opioid Substitution Therapy are available in government supported centres or hospitals free of cost, the client does not have to resort to illegal means. This helps in reducing legal complications faced by the clients and also reduces instances of petty crimes like thefts, etc. in the society.
6. During the illicit drug use phase, Injecting Drug Users are often branded as anti-social or criminal by the families and the society. When on Opioid Substitution Therapy, such Injecting Drug Users are seen as sufferers and 'patients'. This renewed status helps the clients to seek help for other problems as well and makes them amenable for other help that can be provided.

**BENEFITS OF OPIOID SUBSTITUTION THERAPY.**—The benefits accrued from Opioid Substitution Therapy range from HIV prevention to treatment of opioid dependence, and from individual level to family and society

level. The benefits of Opioid Substitution Therapy go beyond HIV prevention alone. A large body of literature is available globally that has documented the benefits and outcomes of Opioid Substitution Therapy. Substantial research has also been conducted in India on the use of Opioid Substitution Therapy in Indian settings. Evidence globally as well as locally shows that Opioid Substitution Therapy leads to improved retention and benefits detailed in the preceding section.

Opioid Substitution Therapy has been endorsed and recommended as the most effective and first-line treatment option for long-term pharmacotherapy of opioid dependence.

#### **BENEFITS OF OPIOID SUBSTITUTION THERAPY.—**

1. Reduction in injecting behaviour.
2. Improved adherence for other treatment, especially treatment for HIV, tuberculosis and viral hepatitis.
3. Reduction in opioid use.
4. Reduced overdose related deaths.
5. Reduction in criminality.
6. Reduction in domestic violence.
7. Improved child care and family ties.
8. Improved productivity.

#### **OPIOID SUBSTITUTION THERAPY-RELATED OUTCOMES – GLOBAL EVIDENCE.—**

- (i) A Cochrane review conducted by Mattick et al., 2009, concluded that Opioid Substitution Therapy using methadone was more effective (in a statistically significant manner) as compared to non-pharmacological treatment in retaining patients undergoing treatment and in suppression of heroin use.
- (ii) A Cochrane review conducted by Mattick et al., 2008, concluded that buprenorphine is an effective maintenance agent for heroin dependence, but not more effective than methadone.
- (iii) Large prospective cohort studies conducted over 18 months found that the odds of HIV infection were 5.4 times greater among those who were not in maintenance treatment compared with those who were in treatment (Metzger et al., 1993).
- (iv) A report by World Health Organisation, 2005, reviewed many studies conducted in different parts of the world and concluded that substitution treatment is a critical component of HIV prevention, and helps in reducing opioid dependency and HIV infection rates.
- (v) A systematic review and cost effectiveness by Connock in 2007 reported the following:
  - (a) All doses of methadone or buprenorphine were more effective in retention as compared to placebo or no therapy.
  - (b) Opioid Substitution Therapy using methadone or buprenorphine in higher dose was more effective in reducing illicit opioid use.
  - (c) A meta-analysis of observational studies spanning publications of 21 years showed that patients on Opioid Substitution Therapy using methadone were four times less likely to die than those not in treatment.
  - (d) Opioid Substitution Therapy using methadone significantly improved HIV-related outcomes (HIV risk behaviours, number of sex partners, frequency of unprotected sex, and rates of seroconversion).
- (vi) A joint position statement of World Health Organisation, United Nations Office on Drugs and Crime and Joint UN Programme on HIV or AIDS, 2004 described the cost effectiveness of Opioid Substitution Therapy as: "According to several conservative estimates, every dollar invested in opioid dependence treatment programmes may yield a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12:1".

**OPIOID SUBSTITUTION THERAPY-RELATED OUTCOMES – INDIAN EVIDENCE.**— As buprenorphine has been in use most commonly in India, much of the evidence in India exists for buprenorphine; some evidence exists for slow release oral morphine, and recently, for methadone.

- (i) Dorabjee and Samson, 1998, describing their experience of implementing buprenorphine-based Opioid Substitution Therapy in a community setting in New Delhi reported that 33% of 447 Injecting Drug Users on buprenorphine stopped injecting, and 35% of those injecting had reduced their frequency of injecting and sharing while on treatment.
- (ii) Kumar MS, 2009 reported that Opioid Substitution Therapy intervention implemented in Manipur and Nagaland covered 1200 Injecting Drug Users and was found to be acceptable to the clients, their families, the general community, religious leaders as well as militant groups.
- (iii) A study by Armstrong et al., 2010, conducted on Opioid Substitution Therapy clients in Manipur and Nagaland showed that the retention rates on Opioid Substitution Therapy was about 73% at 3 months and 63% at 6 months. Statistically significant improvements were observed in relation to sharing of needles, unsafe sex, detention incidents, and quality of life measures.
- (iv) A multi-site study by Dhawan et al., 2010 showed that retention rates on Opioid Substitution Therapy were about 70% at the end of 9 months. The study showed significant decrease in opioid use, high risk behaviours, addiction severity and improvement in quality of life.
- (v) A study conducted across 42 centres by Rao et al., 2012, showed that Opioid Substitution Therapy was being implemented in accordance with the Department of AIDS Control prescribed guidelines; a majority of the clients reported satisfaction with their treatment.
- (vi) Studies on slow-release oral morphine conducted in New Delhi have shown that slow-release oral morphine was associated with decrease in illicit opioid use, improved functioning and reduction in illegal activities (Rao et al., 2005, 2012).
- (vii) A research on methadone implementation across five centres in India showed that it is feasible to implement methadone for Injecting Drug Users in India, and is associated with improved functioning and reduced opioid use (Dhawan et al., 2013).

### KEY CHARACTERISTICS OF OPIOID SUBSTITUTION THERAPY

The practice of Opioid Substitution Therapy is based on a number of principles:

Opioid Substitution Therapy is primarily a medical intervention. The medical staff (doctor and nurse) plays a lead role in Opioid Substitution Therapy intervention. The doctor conducts the assessment and diagnosis, plans and initiates treatment, monitors the progress and side effects, manages co-morbidities and terminates treatment. The nursing personnel dispense the medications, and supervise the administration of Opioid Substitution Therapy medicines. Thus, the Opioid Substitution Therapy intervention is essentially a medical intervention led by the medical team and supported by the psychosocial team.

Adequate dose of medicines is one of the most crucial determinants of a good outcome. The dose of medicines used for Opioid Substitution Therapy needs to be adequate and optimum. In general, the studies have found that the higher the dose, the better the retention in treatment and ultimate outcome.

Long duration of retention in continuous treatment is essential for a good outcome. Opioid Substitution Therapy, as a medical treatment, is expected to last for a long duration, ranging from months to years. The Opioid Substitution Therapy medicines help the clients to stabilise their chaotic lifestyles associated with drug use and assists them to improve other areas of functioning, such as familial, social and occupational. As the clients settle down in their functioning and are ready, the treatment can be tapered in consultation with the clients and their family members. In many instances, the treatment needs to be continued over years to maintain the benefits accrued by the clients. Thus, there is no fixed formula for determining the optimum duration of treatment of Opioid Substitution Therapy; the key factor in determining the duration is 'attainment of treatment goals' viz., achieving a substance-free lifestyle, optimum psychosocial functioning and reintegration into the society.

Combining psychosocial interventions along with dispensing of medicines forms the complete treatment package. Opioid Substitution Therapy works best if psychosocial interventions are combined along with Opioid Substitution Therapy medicines. Psychosocial interventions help in improving retention, and minimise drop-out, assisting the clients in regaining family and social ties and in gainful employment.

Involving the clients at all the treatment stages is crucial for success. Opioid Substitution Therapy works best if clients are involved in the decision-making process of Opioid Substitution Therapy intervention. Thus, the clients need to be involved in setting treatment goals, deciding the dose of treatment, the duration of treatment and the endpoint of treatment. These decisions, if taken along with client, help in improving client retention and outcome on Opioid Substitution Therapy.

#### **OPIOID SUBSTITUTION THERAPY MEDICINES.—**

The medicines used in Opioid Substitution Therapy should have certain properties that help the clients obtain the benefits discussed above. The Opioid Substitution Therapy medicine should:

Have action similar to the illicit opioid used by the clients. This is essential to effectively suppress the craving and withdrawals associated with cessation of opioid use. This means that an Opioid Substitution Therapy medicine should also be an agonist on the opioid receptors.

Have lesser addiction potential as compared to the illicit opioid being consumed by the client. Any Opioid Substitution Therapy medicine will have some liability to result in addiction, as it is an opioid. However, its street value should be much less than the illicit opioids, i.e. users should not prefer the Opioid Substitution Therapy medicine over illicit opioids for their addiction or intoxication.

Be easy to administer i.e. the medicine should be effective on oral or sublingual administration.

Have action lasting for at least 24 hours, so that the frequency of administration should be once a day at the maximum.

Be well tolerated. The side effects should be minimal so that the clients find it acceptable to continue Opioid Substitution Therapy medicines for a long period of time.

Be cheaper, easily available, easily stored and transported, so as to provide for a large number of clients with minimal financial or logistic constraints.

In India, methadone, buprenorphine and slow release oral morphine have been used as Opioid Substitution Therapy medicine. However, the use of buprenorphine exceeds that of the other two; Opioid Substitution Therapy programme under National AIDS Control Programme currently uses buprenorphine as the Opioid Substitution Therapy medicine, and hence buprenorphine has been discussed in detail in subsequent sections. Methadone based Opioid Substitution Therapy is also being implemented as a pilot at five sites in India.

#### **PHARMACEUTICAL COMPOUNDS COMMONLY USED AS OPIOID SUBSTITUTION THERAPY MEDICINES**

- (i) **Methadone.**—Methadone was the first and currently, the most common opioid used as an Opioid Substitution Therapy medicine globally. Methadone is a pure opioid agonist, available for oral use either as a liquid or as a tablet.
- (ii) **Buprenorphine.**—Buprenorphine is a partial opioid agonist available for use as a sublingual tablet.  
It is the second most commonly used Opioid Substitution Therapy medicine worldwide.
- (iii) **Slow Release Oral Morphine.**—Morphine is a pure opioid agonist and commonly used in cancer patients for alleviation of pain. The slow release formulation is available as a tablet.

**STATUS OF OPIOID SUBSTITUTION THERAPY IN INDIA.—** Opioid Substitution Therapy is currently available in 77 countries; of these, most countries use methadone as the Opioid Substitution Therapy medicine, followed by buprenorphine. In India, Opioid Substitution Therapy has been available since the early nineties, when buprenorphine started being used in some Government hospitals as well as in some NGO settings. While the Opioid Substitution Therapy was available uninterruptedly in a few Government hospitals for both Injecting Drug User as well as non-Injecting Drug User opioid dependent users, the availability in Non-



Governmental Organisations was dependent upon funding from donor partners and restricted to only Injecting Drug User population (as a HIV prevention tool). The NGO Opioid Substitution Therapy centres were subsequently supported under National AIDS Control Programme, while the Government centres continued to provide Opioid Substitution Therapy for opioid dependent individuals through funding from the Ministry of Health and Family Welfare. Additionally, there are anecdotal reports of Opioid Substitution Therapy being provided through private drug treatment centres.

The large scale expansion of the Opioid Substitution Therapy programme began with the transition of existing Opioid Substitution Therapy interventions for HIV prevention by National AIDS Control Programme in 2008, after its formal incorporation in 2007. Initially, the existing NGO Opioid Substitution Therapy centres were evaluated and accredited, and those which were found eligible were provided support by Department of AIDS Control. A total of 55 such centres were provided continued support for Opioid Substitution Therapy implementation among Injecting Drug Users. To further expand the Opioid Substitution Therapy programme, existing government hospitals at district and sub-district levels were roped in, and Opioid Substitution Therapy was initiated through the collaborative public healthcare model. Thus, currently there are two models of Opioid Substitution Therapy being implemented under National AIDS Control Programme.

#### **NGO OPIOID SUBSTITUTION THERAPY CENTRES.—**

- (a) Part of Injecting Drug User Targeted Intervention set-up. Staff largely shared with the Injecting Drug User Targeted Intervention.
- (b) Opioid Substitution Therapy centre located within the Drop-in Centre of the Injecting Drug User Targeted Intervention.
- (c) Medical intervention delivered by a trained part-time doctor and full-time nursing. Staff.
- (d) Outreach and follow-up by the outreach staff of the Injecting Drug User Targeted Intervention

#### **COLLABORATIVE PUBLIC HEALTH OPIOID SUBSTITUTION THERAPY CENTRES.—**

- (a) Opioid Substitution Therapy intervention jointly between the Government hospital and nearby Injecting Drug User Targeted Intervention.
- (b) Opioid Substitution Therapy centre located in Government hospital (Medical College or District Hospital or Community Health Centre or Primary Health Centre).
- (c) Separate staff at Opioid Substitution Therapy centre for medical and psychosocial intervention.
- (d) Outreach and follow-up by the Injecting Drug User Targeted Intervention.

## **Buprenorphine—Basics of Pharmacology**

As described above, the opioid family consists of a number of substances that act like opium (hence called opioids as they are similar in action to opium). The opioids have an effect mainly through their actions on the opioid receptors situated in the brain and other organ systems. There are three types of opioid receptors in the human body: mu, kappa and delta; out of these, the main action is produced by action on mu receptors. The opioids are classified as agonists, partial agonists and antagonists based on the nature of action produced on opioid receptors.

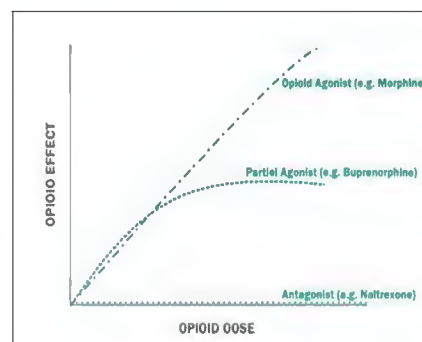
Buprenorphine is a semi-synthetic opioid derived from the baine, an alkaloid of opium. As an analgesic, buprenorphine is 25–50 times more potent than morphine. Used intravenously, 0.3 mg of buprenorphine is equivalent to 10 mg of morphine.

#### CLASSIFICATION BASED ON THE ACTIONS ON OPIOID RECEPTORS.—

- (a) **Agonists:** Opioid agonists bind to and activate the mu receptors, thereby exerting 100% action-producing opioid-like effects. Examples of agonists include: morphine, codeine, dextropropoxyphene, heroin and methadone.
- (b) **Partial agonists:** Partial agonists exert less than 100% action on the mu receptors producing gpioid-like effects, but less than opioid agonists. Example of partial agonist includes buprenorphine.
- (c) **Antagonists:** Antagonists bind to the mu receptors, but do not produce any actions by themselves. However, once they are bound to the receptors, they do not allow the opioid agonists to occupy and act on the receptors, thus blocking the opioid actions. Additionally, if the opioid agonists are already present at the receptors, they displace the agonists, thereby producing opioid withdrawal syndrome. Examples of antagonists include Naloxone and Naltrexone.

**PHARMACOLOGY.**—The pharmacological properties of buprenorphine and its clinical implications are described below.

- (i) Buprenorphine is a **partial agonist of mu receptors** and an antagonist of kappa receptors. With lower doses, the action of a partial agonist is similar to that of a full agonist. As the dose increases, the effects of both the partial agonist and the full agonist are increased. However, beyond a certain dose-point, further increase in buprenorphine dose does not increase the opioid effect. This is called as '**ceiling effect**'. The figure below illustrates the point.



**Fig: Ceiling effect of Buprenorphine**

**Clinical Implication.**—The chances of overdose-related respiratory depression and consequently death are minimal with higher doses of buprenorphine. This is unlike pure agonists, where higher doses can result in overdose-related deaths due to respiratory depression.

- (ii) Buprenorphine has a **high affinity for opioid mu receptors.**— Buprenorphine binds to the opioid receptor much more tightly than other full agonists such as morphine, heroin or methadone. Thus, buprenorphine displaces morphine and other full agonists if it is administered to individuals whose opioid receptors are occupied by the full agonists. Conversely, if the opioid receptors are already occupied by buprenorphine, it is difficult for full agonists to displace buprenorphine.

**Clinical Implication.**—Buprenorphine can displace illicit opioids from the opioid receptors; however, as buprenorphine is a partial agonist, while illicit opioids such as heroin are full agonists, there is a net decrease in the opioid actions. This results in 'precipitated' withdrawals in the individual, if a sufficient gap between the last dose of illicit opioids consumed by the patient and the first dose of buprenorphine is not maintained. Conversely, once buprenorphine occupies the receptors, it is difficult for full agonists such as heroin to displace buprenorphine from the receptors, and produce their own actions. Thus, buprenorphine creates an opioid blocking effect. However, this blocking effect is dose-dependent – higher dose of buprenorphine blocks opioid receptors more effectively than lower doses of buprenorphine.

- (iii) Buprenorphine dissociates from opioid receptors slowly as compared to other opioids. Thus, buprenorphine is a long-acting opioid with terminal elimination half-life of 24 to 37 hours. Peak clinical effect occurs one to four hours after sublingual administration. The duration of the effect depends on the dose administered: a low dose of 2 mg of buprenorphine produces clinical effect for up to 12 hours while higher doses of 16 mg can produce effects lasting up to 48 hours.

**Clinical Implication.**—At the right doses, buprenorphine can be administered at a frequency of less than once per day. It is possible for buprenorphine to be administered every alternate day and in some cases, once in three days too.

- (iv) Buprenorphine undergoes extensive metabolism in the liver, and is converted into nor-buprenorphine and other products through the cytochrome P450 3A4 Enzyme. The metabolites do not have a major effect on the brain due to their poor penetration. Most of the metabolites are excreted through faeces, and some through urine.

**Clinical Implication.**—Due to high first-pass metabolism, buprenorphine has poor oral bioavailability, less than 10% compared to that when given intravenously. Hence, buprenorphine is not clinically effective when given orally. Buprenorphine should be administered sublingually to bypass the high first-pass metabolism. The bioavailability by the sublingual route is about 50 to 60%.

As buprenorphine is metabolised through the liver, care should be taken in those individuals who have deranged liver functioning. This is true in cases of alcohol or viral hepatitis-induced hepatic insufficiency. The metabolism of buprenorphine becomes erratic in such cases, and dose titrations may be required.

As buprenorphine is poorly absorbed orally, its **effect would be milder if it is accidentally ingested**. The ceiling effect adds to its safety in accidental ingestion.

**SIDE EFFECTS AND SAFETY PROFILE.**—Buprenorphine is generally well-tolerated by drug-using individuals. Serious side effects are rare. Common side effects are generally related to the therapeutic dose (please see the accompanying box). Due to partial agonist and 'ceiling effect' property, buprenorphine does not result in respiratory depression even if it is administered at higher than therapeutic doses. In this regard, buprenorphine scores over other opioid agonists used in substitution therapy such as methadone and oral morphine. However, respiratory depression can occur even at low doses, if buprenorphine is combined with other brain depressants such as alcohol or sedatives.

#### **COMMON SIDE EFFECTS.—**

- (a) Constipation (can be due to higher dose).
- (b) Sedation (can be due to higher dose).
- (c) Sleep disturbances.
- (d) Body aches or pains (features of withdrawals; can be due to lower dose).
- (e) Nausea or vomiting.
- (f) Itching (in few cases and in the initial days).
- (g) Dizziness.
- (h) Headache.
- (i) Sweating.

Buprenorphine has no major effect on hepatic functioning. Buprenorphine does not have any major effect on psychomotor functioning as compared to opioid agonists. Thus, individuals can continue to engage in potentially hazardous work such as driving or operating machinery. Precautions need to be taken mainly during the initial few days during dose induction or during increase in doses.

**DRUG INTERACTIONS.**—Drug interactions with buprenorphine can occur due to the action of buprenorphine on opioid receptors or due to the metabolism of buprenorphine.

- (i) **Sedatives.**—The brain depressant effect of buprenorphine is additive to concomitant use of sedatives. These sedatives include—benzodiazepines, barbiturates and alcohol. While buprenorphine by itself does not cause respiratory depression, respiratory depression can occur even with lower doses of buprenorphine if high doses of sedatives and alcohol are concomitantly used with buprenorphine. This is particularly a concern among those drug users who have decreased respiratory reserves due to co-morbid conditions such as chronic obstructive pulmonary disease (COPD), pneumonia, etc.
- (ii) **Opioid agonists.**—Buprenorphine prevents other opioid agonists from exerting their effect due to strong affinity to opioid receptors; conversely, buprenorphine displaces opioid agonists resulting in precipitated withdrawals, as described above.
- (iii) **Hepatic enzyme Inducers or Inhibitors.**—As mentioned above, buprenorphine is metabolised in the liver through the cytochrome p450 3A4 enzymes. As a result, medications that induce cytochrome p450 3A4 enzymes can lower the blood levels of buprenorphine, thereby requiring an increase in the dose of buprenorphine. Conversely, medications that inhibit cytochrome p450 3A4 enzymes can increase the blood levels of buprenorphine, thereby requiring a decrease in the dose of buprenorphine. In both scenarios, clinicians need to monitor for the emergence of opioid withdrawal or intoxicating symptoms and decide on dose titration accordingly.

**COMMON MEDICATIONS INDUCING CYTOCHROME P450 3A4 ENZYMES.—**

(Buprenorphine dose may have to be increased)

- (a) **Anti-epileptics.**—Carbamazepine, Phenobarbital, Phenytoin  
(b) **Anti-tubercular drugs.**—Rifampicin  
(c) **Anti-retrovirals.**—Efavirenz, Nevirapine

**COMMON MEDICATIONS THAT INHIBIT CYTOCHROME P450 3A4 ENZYMES:**

(Buprenorphine dose may have to be decreased) **Anti-fungals:** Flucanazole, ketoconazole.

- (a) **Antibiotics:** Erythromycin.  
(b) **Anti-depressants:** Fluoxetine, Fluvoxamine, Paroxetine.  
(c) **Anti-retrovirals:** Indinavir, Ritonavir, Saquinavir.

**CONTRAINDICATIONS.**—The only absolute contraindication for buprenorphine is known hypersensitivity to buprenorphine.

**PRECAUTIONS.**—In some conditions, the clinician has to assess the primary conditions and use buprenorphine cautiously depending upon the status of the primary condition. Some of these conditions include:

- (i) **Respiratory conditions:** Asthma, chronic obstructive pulmonary disease, kyphoscoliosis, etc..  
(ii) **Hepatic conditions:** Alcoholic liver diseases, viral hepatitis B and C.  
(iii) **Abdominal conditions:** Irritable bowel syndrome and other colonic conditions.



- (iv) **Urological conditions:** Conditions causing urinary retention.
- (v) Pheochromocytoma.
- (vi) Hypothyroidism.

**However, it should be noted that mere presence of the conditions mentioned above should not preclude use of buprenorphine in an opioid dependent individual.**

**ABUSE LIABILITY.**—As buprenorphine is an opioid mu receptor agonist (though partial agonist), it is liable to be abused. In individuals who are not dependent on opioids, buprenorphine use through sublingual route produces euphoria and other opioid-like effects, thus increasing the likelihood that buprenorphine tablets can also be abused. Among drug users, buprenorphine is often the preferred opioid used for injecting in India. As sublingual buprenorphine is easily dissolvable in water, it can be diverted for injection purposes. Thus, one should exercise caution in dispensing of buprenorphine to opioid dependent individuals, and hence in the National AIDS Control Programme, buprenorphine is almost always dispensed as Directly Observed Treatment (described later). However, it must be remembered that abuse liability of buprenorphine is significantly lower as compared to full agonists like heroin, morphine and methadone.

**FORMULATIONS AND LEGAL STATUS IN INDIA.**—Currently, in India, buprenorphine is available both in injectable and sublingual tablet form. The injectable form is commonly available as 2 ml ampoules with each ml containing 0.3 mg of buprenorphine. The injectable form is used as an analgesic. The sublingual tablets of buprenorphine are currently available in three strengths – 0.2 mg, 0.4 mg, and 2 mg.

Buprenorphine is classified as a 'psychotropic' under the Narcotic Drugs and Psychotropic Substances Act. Under the Narcotic Drugs and Psychotropic Substances Act., narcotics and psychotropics can be used for medical and scientific purposes. However, these medications should be prescribed by a doctor, and can be made available only in Government-recognised centres. The injectable form and the 0.2 mg tablet is available in pharmacies, where these formulations can be sold upon availability of a valid prescription for the same. However, the higher strengths of buprenorphine, i.e. 0.4 mg and 2 mg have been approved only for the purpose of treatment of opioid-dependent individuals and can be made available only in Government-recognised drug treatment or de-addiction centres. Both these strengths are available for use in the Opioid Substitution Therapy Programme supported by National AIDS Control Programme.

**Clinical Practice  
Guidelines  
for Opioid Substitution Therapy  
Centres under National AIDS Control  
Programme**

## Clinical Practice Guidelines for Opioid Substitution Therapy Centres under National AIDS Control Programme

The Opioid Substitution Therapy intervention under National AIDS Control Programme is conceptualised as follows:

### OPIOID SUBSTITUTION THERAPY INTERVENTION UNDER NATIONAL AIDS CONTROL ORGANISATION

- a) Opioid Substitution Therapy is a strategy for prevention of HIV among Injecting Drug Users.
- b) Opioid Substitution Therapy is to be provided to Injecting Drug Users (as defined by Department of AIDS Control) who are opioid dependent.
- c) Currently, the only medicine available for Opioid Substitution Therapy is buprenorphine.
- d) Opioid Substitution Therapy is a medical intervention in which a doctor initiates Opioid Substitution Therapy and a nurse dispenses the medicines.
- e) Buprenorphine is to be dispensed on a daily basis as a 'Daily Observed Treatment' regimen.

This section would describe the clinical practices involved in Opioid Substitution Therapy implementation as guided under Department of AIDS Control. The areas covered in this section include:

- (i) Assessment and diagnosis,
- (ii) Determining client suitability for buprenorphine-based Opioid Substitution Therapy,
- (iii) Preparing client for Opioid Substitution Therapy,
- (iv) Initiating buprenorphine (induction phase),
- (v) Continuation on buprenorphine (maintenance phase),
- (vi) Terminating buprenorphine (termination phase),
- (vii) Managing common side effects of buprenorphine,
- (viii) Special clinical situations.

Psychosocial interventions provided along with Opioid Substitution Therapy are not described in this document. It is felt that the discussion on psychosocial interventions warrant a separate document altogether.

## Assessment and Diagnosis

Initial assessment of the client is an essential prerequisite in Opioid Substitution Therapy intervention. The assessment helps the service provider in making appropriate decisions on the client requirement with regard to Opioid Substitution Therapy, including whether Opioid Substitution Therapy should be initiated, as well as the dosing requirements. Assessment has multiple purposes that go beyond mere Opioid Substitution Therapy consideration.

Assessment is to be carried out **both by the counsellor as well as the doctor** of the Opioid Substitution Therapy centre, though the doctor takes a larger role, since Opioid Substitution Therapy is a medical intervention. While the counsellor would focus on the psychosocial aspects of the client's drug use history, the doctor would focus on the clinical or medical aspects pertaining to the client's drug use and medical history. During assessment, the counsellor and doctor must attempt to answer the following questions:

- (i) What are the various psychoactive substances consumed by the client till date?





- (ii) What is the pattern of use of various psychoactive substances consumed by the client?
- (iii) Does the client fulfil the criteria for opioid dependence syndrome?
- (iv) Does the client fulfil the criteria for dependence or harmful use of other substances?
- (v) What is the current pattern of use of various psychoactive substances consumed by the client?
- (vi) What are the various complications in the client's life or functioning due to substance use (including physical, psychological, familial, social, legal, occupational and financial areas)?
- (vii) What are the high risk behaviours practiced by the client (including injecting and sex-related high risk behaviours)? What is the level of knowledge of the client regarding HIV and other consequences of high risk behaviours?
- (viii) What has been the nature of previous attempts by the client to stop injecting or opioid use? What kind of help was received by the client during these previous attempts?
- (ix) What are the major facilitating factors and barriers in the recovery for the client?
- (x) Does the client match the inclusion and exclusion criteria laid down in the programme for initiating Opioid Substitution Therapy?
- (xi) Does the client have any medical condition that makes him or her unfit for Opioid Substitution Therapy?
- (xii) What is the motivation level of the client to stop injecting and initiate Opioid Substitution Therapy?
- (xiii) What is the level of psychosocial support currently available to the client for Opioid Substitution Therapy initiation and continuation?

To answer the above questions, the assessment can be conducted using various modalities covering the following areas:

#### **ASSESSMENT MODALITIES.—**

- a) Interaction with the client.
- b) Interaction with family members (if present during assessment).
- c) Interaction with other individuals associated with the client (client's friends or peers, staff of the Injecting Drug User Targeted Intervention project, if present during assessment).
- d) Review of previous treatment records, if available.
- e) Observation and physical examination of the client.

#### **ASSESSMENT AREAS.—**

- a) Socio-demographic details.
- b) Psychoactive substance use details.
- c) Complications due to substance use.
- d) Injecting and other high risk behaviours.
- e) Past abstinence attempts.
- f) History of medical illnesses.
- g) Current psychosocial support and living arrangement.
- h) Current status of occupational and family functioning.
- i) Evidence of current opioid withdrawals or intoxication.
- j) Evidence of injection or other physical consequences of substance use (injection marks, abscesses, scars, etc.).

(Note: Specific formats exist for recording the information collected during assessment. These formats ("Intake Forms") are prescribed by Department of AIDS Control and provided by the respective State AIDS Control Society to all the Opioid Substitution Therapy centres.)

- (i) **Socio-demographic details** including the client's name, age, sex, marital status, educational status, occupational and employment status, and current contact information are required.
- (ii) **Psychoactive substance use details** including chronological order of initiation of substance use, and for every substance, the age of initiation, progression, frequency of use, mode of intake of substance, any dependence features, usual dose, and last dose of intake have to be noted.
- (iii) **Complications due to substance use** can be psychological (guilt, shame, depression, anxiety, etc.), financial (loss of money, debts, etc.), familial (fights, violence, neglect, homelessness, etc.), social (outcast, ridicule, discrimination, etc.), occupational (loss of job, irregular in work, frequent change of job, etc.), and legal (thefts, robbery, drug dealing or peddling, imprisonment, etc.).
- (iv) **High risk behaviours.**—Both injecting (sharing, reuse of needle or syringes or other paraphernalia) and sex-related (sex with female sex workers, multiple sex partners, sex in exchange of drugs or money, sex under the influence of substances, non-use of condoms) are high risk behaviours.
- (v) **Abstinence attempts.**—Any attempts to give up psychoactive substance use should be noted. For every significant attempt, the duration of attempt, reason for abstinence, type of help received and reasons for relapse should be tracked. An abstinence attempt may be considered as significant if the client was able to completely stop substance use for a duration of 1 month or more.
- (vi) **Psychosocial support.**—The nature of relationship with family members particularly spouse, the nature of relationship with non-drug-using friends, attitude of family or friends towards client's drug use, possibility of involvement in treatment process, etc.
- (vii) **Current living arrangement.**—Type of accommodation, family members sharing accommodation, etc.
- (viii) **Evidence of Injection.**—Any needle track marks, scarring of tissue, abscesses, ulcers, etc.
- (ix) **Evidence of current Intoxication.**—Slurring of speech, altered sensorium, change in rate of speech, disinhibition, gait disturbance, etc.
- (x) **Evidence of current withdrawals.**—Specific to the substance of use.  
 For opioids: Lacrimation, rhinorrhoea, yawning, dilated pupils, increased sweating, restlessness, palpitations, increased respiratory rate;  
 For alcohol or benzodiazepines: Anxiety, restlessness, tremors of hands, increased respiratory rate, palpitations, sweating, etc.

At the end of assessment, the doctor must be able to make a diagnosis of the client's problem and prescribe appropriate management for the same. The diagnosis should encompass the following:

1. **Diagnosis of Opioid dependence.**—Use of opioids in large amounts over a long period of time leading to (presence of three or more among the following in the preceding one year):
  - a) **Tolerance.**—Gradual increase in the amount of opioid intake to get the same high; appearance of withdrawals upon decreasing the dose

- b) **Withdrawal symptoms.**— Lacrimation, rhinorrhoea, yawning, diarrhoea, cramps in abdomen, intense bodyache, insomnia
  - c) **Craving.**— Intense urge to consume opioids
  - d) **Socio-occupational dysfunction**
  - e) **Increased time spent** in obtaining opioids, consuming opioids or recovering from the effect of opioids
  - f) **Continued use of opioids despite harms** incurred due to opioid use, such as abscesses, overdose, vein loss, HIV, hepatitis B or C, respiratory problems, etc.
  - g) **Persistent efforts to cut down opioid use.**— Unsuccessful attempts or desire to give up on opioid use
2. **Diagnosis of other substance use disorders.**—Dependence or harmful use of other substances. Special attention should be given to the concomitant use of alcohol and or benzodiazepines, which are general brain depressants and commonly used by opioid dependent individuals.
3. **Diagnosis of medical co-morbidity, if any.**—Special attention should be given to liver conditions, and respiratory conditions, which, if severe, may preclude a client from being started on Opioid Substitution Therapy.
4. **Psychosocial issues that can influence treatment outcomes.**—Extent of family support, presence or absence of a stable job, current involvement in illegal activities, homelessness, HIV, hepatitis B or C, etc. can influence the retention of the client on Opioid Substitution Therapy, and must be addressed during regular follow-up of the client after Opioid Substitution Therapy initiation.

## **Determining Suitability of Clients for Opioid Substitution Therapy**

To be initiated on Opioid Substitution Therapy, the client must fulfil the suitability criteria mentioned below. Some of these criteria are 'essential' criteria, while others are 'desirable'.

**ESSENTIAL CRITERIA FOR OPIOID SUBSTITUTION THERAPY INITIATION.**—The client must fulfil each of the essential criteria for Opioid Substitution Therapy initiation:

- 1 **DIAGNOSIS OF OPIOID DEPENDENCE SYNDROME.**— A diagnosis of opioid dependence syndrome is essential as Opioid Substitution Therapy is a specific medical treatment for this condition. Merely use of street opioids or injecting drug use is not sufficient to consider Opioid Substitution Therapy. Hence, before starting treatment, the doctor should carefully assess the pattern of opioid use by the client and consider Opioid Substitution Therapy only if the client meets the criteria for opioid dependence discussed above.
- 2 **CURRENT INJECTING DRUG USERS.**—The client should meet the operational criteria for Injecting Drug User established under National AIDS Control Programme i.e. he or she must have injected a psychoactive substance at least once in the past three months for non-medical purposes.
- 3 **ABSENCE OF MEDICAL CONTRAINDICATIONS.**—The client must not suffer from such medical disorders that prevent him or her from being initiated on Opioid Substitution Therapy. It must be remembered that the **only absolute contraindication for Opioid Substitution Therapy with buprenorphine is known hypersensitivity to the medication.** Other conditions such as respiratory, renal or hepatic insufficiency are relative contraindications and do not preclude the use of buprenorphine for Opioid Substitution Therapy. In such instances, the clinician should judge the

possible adverse effects associated with starting buprenorphine versus the benefits of treatment and decide on the course of action on a case to case basis.

**4 INFORMED CONSENT.**—The client must have the mental capacity to provide informed consent, as well as he should be willing to start on Opioid Substitution Therapy after understanding the implications, requirements, safeguards to be taken, etc. Under National AIDS Control Programme, a written informed consent is a must before Opioid Substitution Therapy can be prescribed to any Injecting Drug User.

**5 CLIENT'S WILLINGNESS TO COME DAILY TO RECEIVE TREATMENT.**—At the time of initial assessment, the client should be educated about the need to come to the Opioid Substitution Therapy centre every day to receive treatment under supervision (Daily Observed Treatment Strategy). Only those clients who agree to adhere to this mechanism should be initiated on treatment after duly signing the informed consent.

**DESIRABLE CRITERIA FOR OPIOID SUBSTITUTION THERAPY INITIATION.**—While the following criteria are desirable, they are not essential for a client to be initiated on Opioid Substitution Therapy. These criteria have been included as they increase the likelihood of selecting a suitable client for Opioid Substitution Therapy, thereby increasing the confidence of the clinician in prescribing the treatment.

- (1) **AGE MORE THAN 18 YEARS.**—While it is desirable that the client should be 18 years or above to be initiated on Opioid Substitution Therapy, adolescents who are below 18 years of age can also be given Opioid Substitution Therapy. Issues to be considered in adolescents receiving Opioid Substitution Therapy is discussed in later sections.
- (2) **FAILED ABSTINENCE ATTEMPTS.**—The client may have attempted to give up opioids in the past through other means, but has failed in doing so. This indicates greater likelihood of opioid dependence in a given client as well as lesser chances of recovery with other shorter duration treatments like detoxification.
- (3) **LONG DURATION OF OPIOID USE or INJECTING.**—A history of long duration of opioid use (more than 3 years) indicates high severity of opioid dependence, particularly if the client has used opioids by the injecting route for most of this duration. As Opioid Substitution Therapy is considered the treatment of choice in severe opioid dependence, a client fulfilling this criterion would really require Opioid Substitution Therapy to give up drug use.
- (4) **MOTIVATION TO GIVE UP DRUG USE or INJECTING.**—During the pre-treatment assessment, a client with better motivation is more likely to retain in treatment and accrue the benefits of Opioid Substitution Therapy. However, motivation is a dynamic phenomenon and often clients with poor motivation to abstain at Opioid Substitution Therapy initiation do well with treatment once they experience the effectiveness of Opioid Substitution Therapy in alleviating withdrawals and craving.
- (5) **FEASIBILITY.**—It should be feasible for the client to come to the Opioid Substitution Therapy centre on a daily basis to take his Opioid Substitution Therapy dose. The feasibility here is as per the understanding of the service providers (Opioid Substitution Therapy doctor or counsellor).

However, in situations where the treating team has a different opinion about the ability of a client to come daily, the client's perception of the same should prevail and treatment should be started.

**CONDITIONS REQUIRING SPECIAL CONSIDERATIONS FOR OPIOID SUBSTITUTION THERAPY INITIATION.**—There are certain conditions in which caution should be exercised while prescribing Opioid Substitution Therapy to Injecting Drug Users clients. Among these, the only absolute contra-indication is known hypersensitivity to buprenorphine. In other cases, the clinician should use his or her clinical judgement before deciding on initiation of buprenorphine.

- 1. KNOWN HYPERSENSITIVITY TO BUPRENORPHINE.**— Some clients may have had allergic reactions to buprenorphine in the past; such clients should not be given buprenorphine.
- 2. SEVERE DEPENDENCE ON ALCOHOL OR BENZODIAZEPINES.**— If the clients have concomitant use of alcohol or benzodiazepines, and have higher degree of dependence on these substances through heavy use, Opioid Substitution Therapy may not be started in the Opioid Substitution



Therapy centre itself. Such clients should be referred to a psychiatrist or drug de-addiction centre before initiating on Opioid Substitution Therapy and may require inpatient treatment. Most Injecting Drug Users clients inject a cocktail of opioid drugs (buprenorphine or pentazocine or heroin or d-propoxyphene) along with sedatives (diazepam or pheniramine or promethazine). Such clients are seen as primarily dependent on opioids and can be safely started on Opioid Substitution Therapy.

3. **SEVERE DEGREE OF HEPATIC IMPAIRMENT.**—Alcohol use or infective hepatitis may result in altered metabolism of buprenorphine, leading to erratic blood buprenorphine levels. If there is clinical evidence of hepatic impairment, a liver function test may be advised and based upon the results, the decision regarding Opioid Substitution Therapy can be taken. If the derangement is mild-moderate, Opioid Substitution Therapy should be initiated, but with careful titration of dosage. Opioid Substitution Therapy should be withheld only in case of severe derangement of hepatic function tests or definite clinical evidence of liver failure.
4. **SEVERE DEGREE OF RESPIRATORY PROBLEMS.**—In conditions such as severe asthma or chronic airway diseases leading to severe impairment of respiratory functions, Opioid Substitution Therapy should be initiated with caution, as it may further aggravate respiratory problems. Such patients should not be prescribed benzodiazepines for sleep disturbances due to their additive depressive effect on brain.

**LABORATORY TESTS FOR OPIOID SUBSTITUTION THERAPY.**—It is NOT ESSENTIAL to perform any laboratory test, before initiating Opioid Substitution Therapy for a client. If the doctor has conducted a clinical examination and has not detected any significant finding, Opioid Substitution Therapy can be safely started. It is a good practice to conduct routine laboratory tests (such as hemogram, liver function tests and renal function tests) in the initial days of assessment and treatment as a 'baseline' test. In cases where there are findings present on physical examination, the relevant laboratory tests are warranted.

## **Preparing Clients for Opioid Substitution Therapy**

Once it is decided that the client will be initiated on Opioid Substitution Therapy, he or she should be prepared and educated before initiation. This can be done by the counsellor or the doctor. The important issues to be covered in client education:

- (i) **Nature of illness.**—The client should be explained that opioid dependence syndrome is a chronic relapsing medical illness similar to other chronic medical illnesses such as diabetes, hypertension and other cardiovascular illnesses. It is not a weakness of will power, or a 'character defect' in the client. Relapse is part of the recovery process and there are strategies available to minimise or prevent relapse.
- (ii) **Nature of treatment.**—The client should be informed that Opioid Substitution Therapy is a long-term treatment option; it is important for the client to remain in treatment for at least one year or more for lasting benefits. The medicines would be given as a daily observed treatment supervised by the nursing staff. The medicines would help in controlling withdrawals, and craving, and he would not need to use opioids for at least a 24-hour period after receiving the dose.  
  
Apart from Opioid Substitution Therapy medicine, the client also needs to undergo periodic counselling as well as regular follow-up with the service providers. The client needs to follow the rules and regulations established by the Opioid Substitution Therapy centre.
- (iii) **Need for active involvement.**—The client needs to be involved actively in the treatment process. He or she needs to be forthcoming in informing the service providers about his drug using status, benefits of treatment, sufficiency of medicine dose, and overall improvement. Additionally, if family members are involved in treatment, the outcome would be better.

Along with education, the service providers should also dispel common myths or misconceptions associated with Opioid Substitution Therapy. Additionally, this also provides the service providers an opportunity to enhance the motivation of the client towards initiation and continuation on Opioid Substitution Therapy.

Once the client has clearly understood the implications of being in Opioid Substitution Therapy programme and is ready, he or she should be asked to **sign the informed consent form** and Opioid Substitution Therapy should be initiated only after the consent form is signed. The consent form should have signatures of client, a witness (family member or staff) and the person who has obtained the consent (doctor or counsellor).

## Buprenorphine–based Opioid Substitution Therapy

Opioid Substitution Therapy with buprenorphine can be divided into three phases:

- (i) **Induction phase.**—Phase wherein the client is given the first dose and the dose is subsequently adjusted to achieve a stabilisation dose
- (ii) **Maintenance phase.**—Phase wherein the client is maintained on stabilisation dose till a decision to stop buprenorphine is taken
- (iii) **Termination phase.**—Phase from decision to stop buprenorphine to the last dose of buprenorphine

Each of these phases of Opioid Substitution Therapy treatment has different goals and objectives, management issues, and role of different service providers, etc. Each of these phases is discussed in detail below in different sections.

**INITIATING OPIOID SUBSTITUTION THERAPY WITH BUPRENORPHINE – INDUCTION PHASE.**—As mentioned above, the induction phase begins when the decision to initiate the client on Opioid Substitution Therapy is taken till the point where the stabilisation dose is reached.

### GOALS OF INDUCTION PHASE.—

- (a) To determine the correct dose of buprenorphine for a client to be able to control opioid withdrawal symptoms and craving
- (b) To address any medical or psychosocial crisis faced by the client
- (c) To establish rapport with the client and educate him or her about the treatment process

Before the first dose of buprenorphine, the doctor should ensure that:

- (i) A detailed assessment of the client has been made, and the client fulfils the criteria for Opioid Substitution Therapy initiation as laid down by Department of AIDS Control.
- (ii) The client has understood the implications and procedures of Opioid Substitution Therapy and has signed the informed consent sheet.
- (iii) **The last dose of opioid use is at least 6 to 8 hours before the first dose of buprenorphine.**

The first dose of buprenorphine usually ranges from 2 to 4 mg. After the first dose is administered sublingually, the client should be observed after a gap of two hours, when the peak effect of buprenorphine is expected to be observed. If the client still complains of withdrawals or craving, an additional 2 to 4 mg can be given. If the client reports no symptoms of opioid withdrawal or craving, he or she should be asked to return on the next day for his dose. The total dose of buprenorphine must not exceed beyond 8 mg on day one.



On the second day, enquiry should be made regarding whether the client had any opioid withdrawal or craving symptoms anytime in the last 24 hours after the dose of buprenorphine was initiated or whether the client took any other opioid by injecting or non-injecting routes AND was able to achieve its effects. If the client reports so, the dose of buprenorphine should be increased in increments of 2 mg. The maximum dose of buprenorphine on day two should be about 12 mg. If the client does not report of any withdrawals or craving for an entire period of 24 hours following dose administration, the client would have achieved his stabilisation dose.

**HOW IMPORTANT IS THE TIME GAP BETWEEN LAST DOSE OF ILLICIT OPIOID AND FIRST DOSE OF BUPRENORPHINE?** This is extremely important, especially in cases where the client uses pure opioid agonist such as heroin as the illicit opioid. If the time gap is not maintained, buprenorphine would displace the illicit opioids from the receptors and precipitate opioid withdrawals symptoms, which would be extremely distressing for the client.

However, some doctors have a myth that if the client has already taken an opioid drug (like heroin) a short while ago, the first dose of buprenorphine will result in added intoxication (and risk of overdose). This is a misconception. The gap must be ensured primarily to avoid the precipitated withdrawal and not overdose.

Most clients reach their stabilisation dose in three to four days, maximum by day seven. Apart from control of craving and withdrawal, the stabilisation dose should also be able to block the euphoric effect produced by illicit opioid use. It must be remembered here that lower doses (of up to 2 to 4 mg) would be able to control withdrawal symptoms, while slightly higher doses (of up to 4 to 8 mg) would be able to take care of craving. The opioid blocking effect would be produced only at even higher doses (of 8 to 12 mg). Additionally, the higher the dose of buprenorphine, the longer is the effect of buprenorphine – i.e. a higher dose would enable the client to be without any discomfort or need for additional opioids for longer duration of at least 24 hours duration. Hence, the clinician's efforts must be to ensure that all the three objectives of Opioid Substitution Therapy dose or stopping withdrawals, control craving and produce opioid blocking effect – are achieved with the adequate dose of buprenorphine.

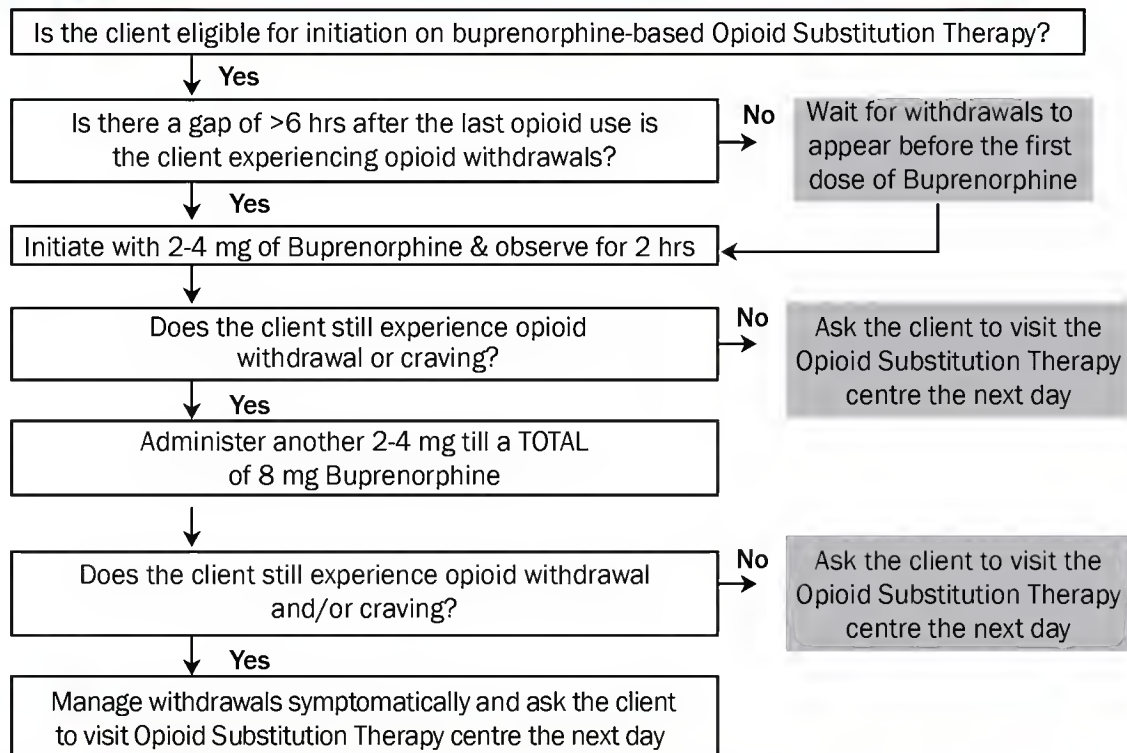
Dose of 2–4 mg/day	• Control of opioid withdrawal symptoms
Dose of 4–8 mg/day	• Control of opioid related craving
Dose of >8 mg/day	• Block effects of other opioids

While guidelines from western countries recommend a maintenance dose of 12 to 16 mg of buprenorphine per day, experience from India shows that for optimum outcomes, doses of 8 to 12 mg of buprenorphine per day is sufficient for most clients. For maximum dose too, the guidelines from western countries suggest a maximum of 32 mg/day; however, in India, a dose of 20 to 24 mg per day can be considered as maximum dose. If the clinician feels that the client is not improving despite the maximum dose, the client may be referred to a higher centre specialising in substance use treatment for further management.

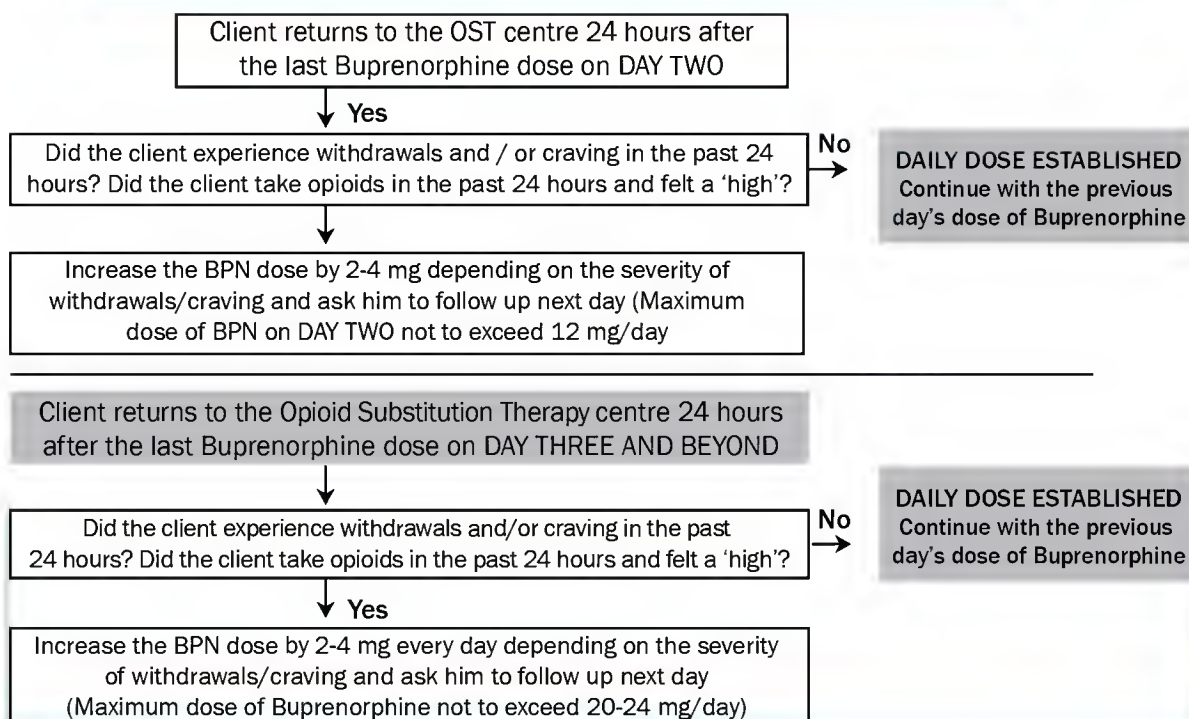
Apart from stabilising the dose of buprenorphine, the service providers also need to work on the following areas of the client's life during induction phase:

- (i) Enhance the client's motivation to stop or reduce injecting and continue Opioid Substitution Therapy.
- (ii) Address any medical priorities. These may include conditions such as an open abscess, active tuberculosis, or any acute co-morbid medical problem faced by the client.
- (iii) Address any psychosocial crisis. This may include conditions such as recent homelessness, impending legal crisis, etc.

### FLOW-CHART ON INDUCTION PHASE FOR BUPRENORPHINE (BPN)- BASED OPIOID SUBSTITUTION THERAPY: DAY ONE



### FLOW-CHART ON INDUCTION PHASE FOR BUPRENORPHINE (BPN)- BASED OPIOID SUBSTITUTION THERAPY: DAY TWO AND BEYOND



**DOSE INCREMENTS FOR BUPRENORPHINE.**—To the extent possible, dose increments should be in round figures, preferably in multiples of 2. Thus, if a client is not comfortable on 4 mg, the next dose should be 6 mg. The fractions (using 0.2 and 0.4 mg tablets) should be limited to only those rare cases where (say) 6 mg is an inadequate dose while (say) 8 mg is perceived as a higher dose. Additionally, the use of fractions can be considered while tapering the dose for the purpose of termination of treatment (described later).

**MAINTAINING CLIENTS ON BUPRENORPHINE – MAINTENANCE PHASE.**—The maintenance phase begins with the client achieving his stabilisation dose till the time a decision is made to stop Opioid Substitution Therapy for the client.

**GOALS OF MAINTENANCE PHASE.—**

- (a) To maintain the client on adequate doses of buprenorphine
- (b) To address other substance use by the client, if any
- (c) To motivate and refer the client for other services, including HIV diagnosis and treatment
- (d) To help the client in regaining occupational, financial and familial stability
- (e) To retain the client in treatment, adhere to treatment regimen and help prevent relapse to opioid use (through injecting or other route)
- (f) To help the client prevent shifting to another substance use

**BUPRENORPHINE MAINTENANCE DOSE.**—The clinician should continue the same dose of buprenorphine as used in the induction phase for stabilisation.

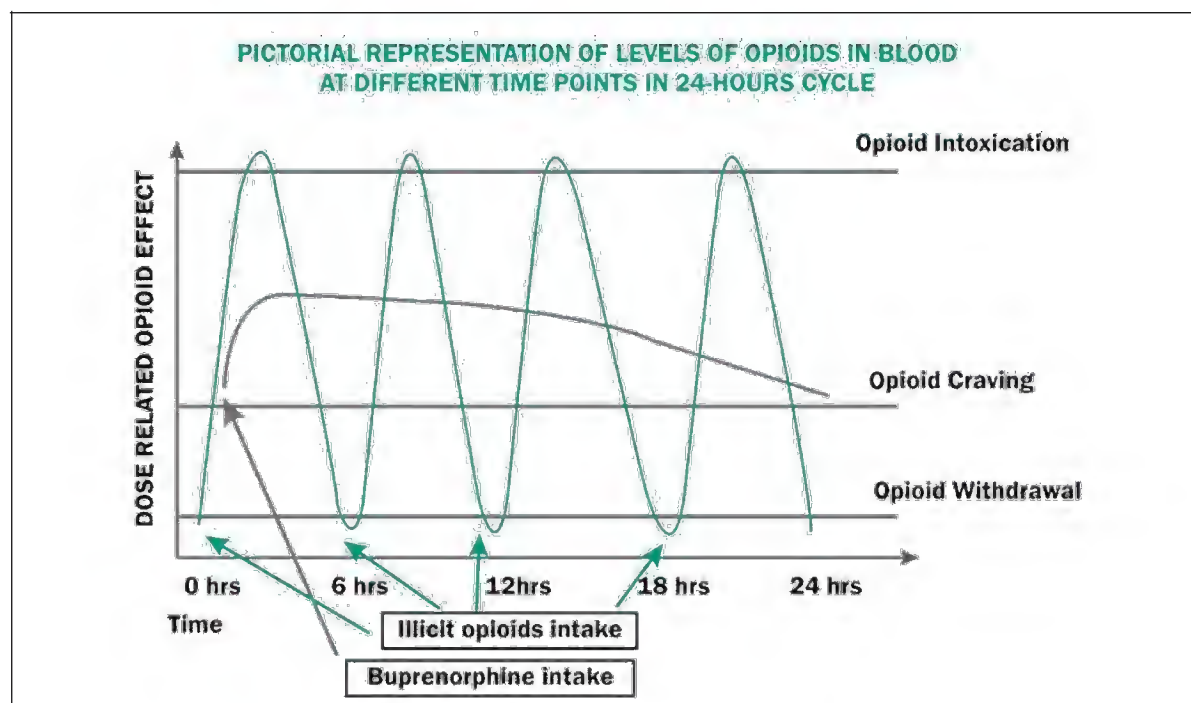
Any temptation to reduce the dose of buprenorphine must be avoided, unless specifically warranted.

Furthermore, the doctor must make enquiries on the following issues during every follow-up:

- (i) Does the client have withdrawals or craving despite his current buprenorphine dose?
- (ii) Has the client used any other opioids or injections while on his current buprenorphine dose?
- (iii) Does the client experience euphoria while using other opioids or injections?

The information regarding the above can be elicited by interviewing the client, his family members or significant others and staff of the Targeted Intervention linked with the centre.

If the clients report that they still have (a) withdrawals or (b) craving or that (c) they use injections or other opioids and experiences euphoria on opioid use, it is an indication to the doctor that the dose of buprenorphine is inadequate. In such cases, the doctor must increase the dose of buprenorphine to an optimum level. Care must also be taken to ensure that the client does not experience opioid intoxication effect due to use of buprenorphine, such as sedation, slurring of speech, incoordination, etc. Such effects are related to the peak plasma blood levels of buprenorphine typically seen 1-3 hours after administration of the daily dose. Thus, the dose of buprenorphine must be such that the client neither has a peak effect of intoxication nor has the trough effect of withdrawal or craving. A pictorial representation of difference between the level of illicit opioids such as heroin and buprenorphine is shown below.



Once the client is maintained on a particular dose of buprenorphine which is comfortable for him or her, the SAME dose should be continued in the maintenance phase. Further changes in dose, especially dose increase, may be required in some conditions. Such conditions may include resumption of work (especially menial jobs such as manual labour, rickshaw pulling, etc.), pain conditions (such as fractures, etc.), re-emergence of craving, psychosocial distress, etc. In such cases, the doctor should re-assess the client and increase the dose as required.

An important issue during maintenance phase is to encourage and motivate clients to continue on Opioid Substitution Therapy. Many clients feel that their lives have become normal after 2 to 3 months of Opioid Substitution Therapy, as they have stopped opioid and injecting use, and feel that they can now stop Opioid Substitution Therapy. This belief is also often supported by family members, who feel that the client should now resume his or her responsibilities, sometimes at the cost of continued Opioid Substitution Therapy. The service providers must emphasise on the need for long-term continuation of Opioid Substitution Therapy medicines. The principles of motivation enhancement can be applied for encouraging the client to continue Opioid Substitution Therapy. Additionally, the family members must also be counselled on the need for continuation on Opioid Substitution Therapy.

**REDUCTION OF MAINTENANCE DOSE.**—It is observed that in certain cases, the doctor reduces the dose of buprenorphine despite the fact that there are no side-effects, the client is maintaining well and has not desired for dose reduction. This reduction is done as many doctors and other Opioid Substitution Therapy centre staff are under the impression that once the client has stopped using illicit opioids, his dose should be reduced to the minimum possible.

It should be important to note that the SAME DOSE OF BUPRENORPHINE AS REQUIRED IN THE INITIAL STAGES SHOULD BE CONTINUED, unless the client reports of any buprenorphine-related side effects. Even if the client requests for dose reduction, he or she should be educated on the need for the same dose. Despite this, if the client demands for dose reduction, then only the dose reduction should be attempted.



**BUPRENORPHINE DISPENSING** As per Department of AIDS Control guidelines, dispensing of buprenorphine is to be done on 'Daily Observed Treatment' basis at the Opioid Substitution Therapy centre. This means that the client has to come to the Opioid Substitution Therapy centre daily and take his medicines in front of the Opioid Substitution Therapy nurse. Buprenorphine is to be given through the sublingual route. The tablet should be crushed before administration to prevent diversion of the medicine by the client. The nurse should observe the client for a period of at least 7 to 10 minutes after administering the dose to ensure that the tablets have dissolved. Detailed dispensing procedure is provided in the document on standard operating procedure.

**ADDRESSING CO-MORBID SUBSTANCE USE.**—Once the client is stabilised on Opioid Substitution Therapy medicines and he has stopped illicit opioid use, use of other substances may increase or resume. This is mainly because the client attempts to find other sources of pleasure and high. Most commonly, the client may reinstate or increase consumption of other brain depressants such as alcohol, benzodiazepines or cannabis. Some clients may progress on to use of these substances in dependent pattern. Apart from problems due to the substances themselves, use of these substances also affects Opioid Substitution Therapy.—

- (i) Use of these substances would increase the chance of the client relapsing to opioid use
- (ii) Use of high dose of these substances would increase the risk of respiratory depression

The service providers should enquire about other substance use during maintenance phase. In case the client has re-initiated or increased his substance use, the service provider must educate the client about the risks posed, and assist the client in stopping the use of these substances. If required, the client may be referred to a psychiatrist or another specialist dealing with substance use disorder for treatment of these co-morbid conditions.

**REFERRAL TO OTHER SERVICES.**—Once the client is stabilised on Opioid Substitution Therapy, he or she becomes more amenable to availing other services required. The client should be motivated to undergo HIV testing and if found HIV positive, should be encouraged to register with an Anti-Retroviral Treatment centre for further management. Additionally, the client should be clinically screened for other conditions including tuberculosis, hepatitis, abscesses, etc. If the client is found to be suffering from any of these medical conditions, appropriate referral must be made. The client should also be encouraged to adhere to both Opioid Substitution Therapy as well as medications prescribed for such co-morbid conditions.

**ASSISTANCE IN RE-INTEGRATION.**—Maintenance phase is an excellent opportunity to motivate the client to repair ties with family, assume family responsibility and regain employment. Such re-integration with work, family and society would further help the client in maintaining abstinence from substance use and help regain the trust of his family members. Occupational rehabilitation makes the client productive once again and helps him or her to have a structured routine as well as earn a livelihood.

During follow-up, the counsellor should explore these areas and assist the client in resuming his work and ties with family. The family members should be involved in these activities, and help from them solicited if required through a home-visit.

#### **TERMINATING CLIENTS ON BUPRENORPHINE – TERMINATION PHASE.—**

The termination phase begins with taking a decision to stop buprenorphine and ends when the last dose of buprenorphine is administered to the client.

##### **GOALS OF TERMINATION PHASE**

- (a) To taper and stop buprenorphine medicine
- (b) To ensure that clients have minimal discomfort during tapering of buprenorphine
- (c) To support the client during tapering of buprenorphine and prevent relapse during the same
- (d) To help the client in making decision regarding further treatment after stopping Opioid Substitution Therapy
- (e) To motivate the client for continued follow-up after stopping Opioid Substitution Therapy

**DECISION TO STOP BUPRENORPHINE.**— A crucial decision in Opioid Substitution Therapy management is the decision about stopping buprenorphine treatment. There is no specified time-duration for a client to be maintained on Opioid Substitution Therapy. Opioid Substitution Therapy may last for months to years. The endpoint is reached upon the client achieving the treatment goals decided mutually by him or her and the service provider during the initiation of Opioid Substitution Therapy. The treatment goal is not limited to the client stopping his or her drug use; it also includes successful reintegration of the client in his or her family, society and work. Once these goals are reached, a decision on stopping buprenorphine can be made, if the client wishes to stop buprenorphine.

Some indicators of successful termination can include.—

- (a) cessation of opioid and injecting use,
- (b) cessation of illegal activities,
- (c) improved ties with family,
- (d) strong psychosocial support,
- (e) well-maintained occupational functioning, and
- (f) client's readiness to lead a medication-free life.

Despite successful outcomes, clients may still wish to continue Opioid Substitution Therapy, as they are not ready or willing to lead a medication-free life, in which case, Opioid Substitution Therapy must be continued. Continued drug use, continued perception of risk of relapse, illegal activities, poor occupational functioning, homelessness, and poor family support are the factors which indicate that Opioid Substitution Therapy should continue and should not be terminated irrespective of the duration of treatment.

**TAPERING BUPRENORPHINE.**—Before tapering of buprenorphine, the client must be prepared well in advance. The family members should be involved in the decision, and support from them must be solicited. The client must be educated on the possibility of some discomfort and withdrawals during taper and relapse prevention sessions for the client must be conducted.

Buprenorphine must not be stopped abruptly, as otherwise the client would experience withdrawals and there would be the consequent risk of relapse to opioid use. The process of tapering must be gradual. There is no fixed regime for tapering buprenorphine dose; the amount of reduction, time-gap between each reduction and the time taken for the tapering process varies from client to client. For most clients, tapering can be done on an outpatient basis in the centre itself; very few clients may require admission to a hospital for tapering of buprenorphine.

**TAPERING TO A LOWER MAINTENANCE DOSE.**—In clinical practice, a situation is often encountered when during the process of tapering, the dose is lowered (say, from 8 mg per day of maintenance dose to 2.4 mg per day) and any subsequent dose-reduction is met with discomfort. In such cases, clients are continued on this lower maintenance dose for many months or years.

The outpatient taper can be done over 2 to 3 months duration. In outpatient tapering, the tapering can be done in units of 2 mg of buprenorphine every 4 to 7 days, till the client reaches a dose of 2 to 4 mg of buprenorphine. Further tapering can be done in units of 0.4 to 0.8 mg of buprenorphine every 4 to 7 days. If the client complains of withdrawals or discomfort, the tapering can be more gradual. Inpatient tapering can be faster than outpatient tapering and can be achieved in 2 to 3 weeks' time. In an inpatient setting,



the daily dose of buprenorphine can be divided into a thrice-daily regime, and 0.4 to 0.8 mg of buprenorphine can be reduced daily. Some clients experience greater discomfort as they reach the last few doses of buprenorphine, in which case the minimum dose can be continued for a longer period of time, before finally stopping buprenorphine.

**MANAGEMENT AFTER TERMINATION OF BUPRENORPHINE.**—Following termination of treatment, the client must be educated on the importance of continued follow-up. The follow-up can be frequent initially, once in two weeks or so, and later at a frequency of once in 1 to 3 months. During such a follow-up, enquiry must be made regarding the client's drug-using status, occupational and familial functioning, as well as re-emergence of withdrawals and craving for opioids. Relapse prevention sessions must be continued during this phase.

Post termination of buprenorphine, the client can remain free of any medication and continue follow-up at the Opioid Substitution Therapy centre. In some cases, the client can be started on antagonist maintenance. For antagonist treatment, the tablet naltrexone (at dose of 50 mg/day) should be given once a day. Before starting naltrexone, the client must be free of any opioids for at least 72-hour duration. Unlike buprenorphine or other opioid agonists, naltrexone is not a controlled drug, and can be purchased from local pharmaceutical shops. Antagonist treatment can be continued for a period of 6 to 12 months, during which the client will be fully confident of leading an opioid-free life. The medication can be stopped abruptly and does not require any tapering, unlike the agonist medicines.

If the client relapses at any stage of Opioid Substitution Therapy, he or she should be re-initiated on Opioid Substitution Therapy after assessment and diagnosis.

The principles and practices of Opioid Substitution Therapy remain the same as described earlier.

#### **CRITICAL ISSUES IN OPIOID SUBSTITUTION THERAPY PROGRAMME**

- (a) Selection of appropriate clients for Opioid Substitution Therapy,
- (b) Optimal dosing of buprenorphine,
- (c) Proper dispensing procedures,
- (d) Attitude of staff: Staff attitude plays an important part in attracting clients to the Opioid Substitution Therapy programme and ensuring their retention,
- (e) Provision of other services to the Opioid Substitution Therapy client,
- (f) Stock management: It should be ensured that the stocks of buprenorphine are properly maintained and replenished at regular intervals, so that there is no stock-out situation in the centre,
- (g) Record maintenance: The prescribed records should be properly maintained at the Opioid Substitution Therapy centre,

*Further details on the record maintenance and stock management can be found in the document on standard operating procedure.*

## Management of Common Clinical Situations

During Opioid Substitution Therapy, a number of clinical situations may be encountered which require management by the service providers of the Opioid Substitution Therapy clinic.

**VOMITING.**—Vomiting does not occur commonly with buprenorphine-based Opioid Substitution Therapy. Vomiting may occur in the initial period of initiation of buprenorphine, and usually subsides within a few days. The client may be prescribed oral anti-emetics, which can be administered half an hour before taking buprenorphine.

**CONSTIPATION.**—Constipation is a common side effect of buprenorphine-based Opioid Substitution Therapy. A client complaining of constipation after buprenorphine initiation should be evaluated to rule out other causes of constipation. If an obvious cause is detected, appropriate treatment should be provided either by the Opioid Substitution Therapy doctor or through referral. Enquiry should also be made regarding any symptoms and signs of buprenorphine intoxication, such as increased drowsiness, gait abnormalities, slurring of speech, etc. If the symptoms or signs of buprenorphine intoxication are present, a careful reduction in dose may be helpful in relieving constipation. If no organic pathology is detected, conservative measures should be instituted initially. The client may be advised dietary change, increased consumption of water, increased physical activity, etc. If these measures do not improve constipation, the client may be prescribed laxatives. If all of these measures do not help improve constipation, the doctor should then consider decreasing the dose of buprenorphine. In many cases, constipation may be a trade-off — instead of experiencing constipation with the same dose of buprenorphine or undergoing the risk of withdrawal or relapse if the dose is lowered to relieve constipation.

**SLEEP DISTURBANCE.**—Sleep disturbance is common among Opioid Substitution Therapy clients, and include delayed initiation in sleep onset, or frequent waking up at nights. Very often, clients inject cocktails of opioids along with other sedative or hypnotics such as chlorphenaramine, promethazine or benzodiazepines. Additionally, the client may be abusing benzodiazepine tablets along with injecting drug use. During Opioid Substitution Therapy, while the opioid-related withdrawals are taken care of by administration of buprenorphine, withdrawals related to sedatives are not addressed, which leads to sleep disturbance.

If the client is dependent on benzodiazepines, management of benzodiazepine dependence must be undertaken independent of Opioid Substitution Therapy. For sleep disturbance, the client may be educated on sleep hygiene. If these measures fail, the client can be prescribed low dose benzodiazepines (tab. diazepam or nitrazepam 5 to 20 mg at night) or other sleep-inducing medications such as mirtazapine (7.5 to 15 mg at night in tablet form), trazadone (50 mg at night in tablet form), or dothiepin (25 to 75 mg in tablet form). While prescribing benzodiazepines, it must be remembered that clients can also become habituated or dependent on benzodiazepine medications; hence the dose of benzodiazepines must be kept low and should be prescribed for the shortest duration possible.

**SLEEP HYGIENE.—**

- (a) Fix the time for going to bed and getting up in the morning.
- (b) Avoid afternoon naps.
- (c) Have meals 2 hours before sleep.
- (d) Avoid stimulants such as coffee, tea or nicotine after sunset.
- (e) Avoid stimulating activities such as watching television before going to sleep.
- (f) Take light exercise in the evening.
- (g) Have a bath with warm water before going to sleep.
- (h) Do light reading or listening to music before sleep.
- (i) Use the bed only for sleep.

**MISSED DOSES.**—As Opioid Substitution Therapy is a long-term treatment and requires daily dosing, often clients miss their doses in-between and come back for treatment after a gap of a few days. In such situations, the management will depend on the duration of the missed treatment:

- (i) If the client misses one day's dose of buprenorphine, the client can be given the same dose of buprenorphine as before.
- (ii) If the client misses two–three days' dose of buprenorphine, enquiry must be made by the doctor regarding whether the client has consumed any opioids in the intervening period, or whether the client is in withdrawals currently. If the client is in withdrawals, he or she can be given the same dose as before. If the client has consumed any opioids in the intervening period, and he does not have withdrawals currently, the client may be given half the dose of buprenorphine and the dose can be gradually increased depending on the client's response in the subsequent days.
- (iii) If the client misses his dose of buprenorphine for more than three days, the same dose of buprenorphine should not be given to the client, as tolerance to opioids can be lost even within three days. The client should be treated as a 'new' client and buprenorphine should be re-inducted, starting from induction phase till the client is stabilised.

## Management of Special Clinical Conditions

**CO-MORBID HIV INFECTION.**—Service providers of Opioid Substitution Therapy intervention would commonly encounter Opioid Substitution Therapy clients who have been diagnosed with HIV infection, and are on Anti-Retroviral Treatment medications. The following points must be taken into consideration during co-morbid HIV infection:

- (i) All efforts must be made to ensure that every Injecting Drug User client who is on Opioid Substitution Therapy should be referred to Integrated Counselling and Testing Centre for HIV testing after pre-test counselling. If the client is tested as HIV positive, he or she should be referred to Anti-Retroviral Treatment centre for registration and for decision on initiation of Anti-Retroviral Treatment medicines. If the client is HIV negative, he or she should be educated on high risk behaviours and strategies to prevent high risk behaviours as well as HIV prevention during high risk behaviours. The doctor need not wait for the HIV test results before initiation on Opioid Substitution Therapy.
- (ii) If a client is already diagnosed as HIV positive during the initial assessment, the client can be initiated on Opioid Substitution Therapy and referred to Anti-Retroviral Treatment centre for the initial HIV-related assessment and investigations. The client can be stabilised on Opioid Substitution Therapy before initiation on Anti-Retroviral Treatment, which will help in improved adherence on Anti-Retroviral Treatment.

Though some drug-drug interactions are observed between buprenorphine and ART medications, these are often not clinically significant to warrant change in dose of either buprenorphine or ART medicines. The doctor should be guided by the clinical signs and symptoms for changing the dose of buprenorphine. If symptoms of opioid withdrawal are noticed or the client complains of discomfort after initiation of ART during Opioid Substitution Therapy maintenance phase, the doctor should increase and titrate the dose of

buprenorphine as per the client's comfort level. Similarly, the dose of buprenorphine should be decreased if the client complains of excessive drowsiness, slurring of speech, gait instability or other features of intoxication after initiation of ART medicines. A list of Anti-Retroviral Treatment medicines that can interact with buprenorphine is provided in Annexure A.

**TUBERCULOSIS.**—Tuberculosis is a common co-morbid condition among Injecting Drug Users. Hence, every client should be clinically assessed for tuberculosis during initiation on Opioid Substitution Therapy. If there is clinical suspicion, the client should be referred to a Tuberculosis centre for sputum testing and chest X-ray. The adherence to Tuberculosis treatment improves if the client is on Opioid Substitution Therapy. Some Tuberculosis medications can have interactions with buprenorphine. Rifampicin is a cytochrome p 350 enzyme inducer and can increase the clearance of buprenorphine. Isoniazid can cause hepatic damage, which in turn can alter the metabolism of buprenorphine. The doctor should titrate the dose of buprenorphine accordingly.

**HOWEVER, SUSPECTED TUBERCULOSIS OR CURRENT ANTI-TUBERCULAR TREATMENT BY THEMSELVES DO NOT PRECLUDE WITHHOLDING OR DELAYING INITIATION OF OPIOID SUBSTITUTION THERAPY.**

**ADOLESCENTS.**—While buprenorphine is now considered safe for use in anyone above the age of 12 years, the use of this medication for Opioid Substitution Therapy in population aged less than 18 years has not been as systematically studied as for the adult population. Usually, clients from this age-group have short duration of opioid use and even shorter duration of injecting drug use. As a result, a view held commonly by experts is that detoxification followed by antagonist treatment should be tried initially, and if this strategy fails, agonist medications should be considered. However, others are of the view that adolescents also have a high risk of sharing, overdose and other opioid-related complications, and hence, agonist treatment with buprenorphine should be considered for this population. Moreover, detoxification and antagonist treatments are not available everywhere, hence, it is not possible to wait for a trial of such treatments in every opioid-dependent adolescent.

If a client falls in the age group of less than 18 years, **Opioid Substitution Therapy should not be denied straightaway.** A careful assessment of the client's drug use and associated high risk behaviour should be made. Consideration must be given to the duration of opioid use, associated high risk behaviour, especially sharing of injecting equipment and sex-related behaviour. If there is a long history of opioid use (Less than 2 years) along with injecting drug use and associated high risk behaviour, Opioid Substitution Therapy with buprenorphine must be considered. There would be issues around obtaining informed consent, as consent from a person less than 18 years may not be considered valid. Hence, consent from either of the parents, or from a guardian (older than 18 years) may be obtained before initiating Opioid Substitution Therapy, besides obtaining the 'assent' from the minor client.

**FEMALE POPULATION.**—There are some special considerations with opioid dependent female patients who inject drugs. Females are more vulnerable to HIV and other complications due to injecting as compared to their male counterparts. More often than not, females have a male partner who is also an Injecting Drug User, as a result of which they have to use the injections and injecting equipment after the male uses them. Some female Injecting Drug Users resort to sex work to support their drug using habit. In addition, they also have to take care of children, which add to their burden. Female Injecting Drug Users are often looked down upon by the neighbours and the society, resulting in greater stigma and discrimination. Finally, female Injecting Drug Users have lesser accessibility to general healthcare services as well as HIV prevention programmes or drug treatment services. The staff of Opioid Substitution Therapy centre should bear these vulnerabilities in mind when attending to female Injecting Drug Users who wish to be initiated on Opioid Substitution Therapy.

**PREGNANCY AND BREASTFEEDING.**—OPIOID SUBSTITUTION THERAPY IS RECOMMENDED FOR PREGNANT WOMEN DEPENDENT ON OPIOIDS. The process of induction and maintenance is the same as for other patients. Care should be taken to ensure that termination of Opioid Substitution Therapy is not attempted in the first and the third trimester due to risk of abortion or pre-term delivery. The dose of buprenorphine may need to be increased in the third trimester due to increased volume of water during the third trimester of pregnancy. However, this should be done by clinical assessment for withdrawals. Buprenorphine should be continued throughout the labour. The dose of buprenorphine may need to be reduced after delivery. Buprenorphine should be continued after the delivery. Breast-feeding can be continued. Even though buprenorphine is secreted in breast milk, the actual amount of buprenorphine entering the infant's blood may not be high due to high first-pass metabolism.



The staff of the Opioid Substitution Therapy centre should inform the obstetrician and the neonatologist or paediatrician about the dose of buprenorphine that the client is on during delivery. The paediatrician should be made aware of the possibility of neonate experiencing opioid withdrawals after delivery, termed as Neonatal Abstinence Syndrome (NAS). Neonatal Abstinence Syndrome occurs due to the fact that the child in the mother's womb is exposed to buprenorphine. After delivery, buprenorphine levels fall in the child's blood due to non-availability of buprenorphine resulting in opioid withdrawals. Recent studies have shown that Neonatal Abstinence Syndrome with buprenorphine occurs in about one-third of all deliveries, and is mild to moderate in most cases. The clinical features and management of Neonatal Abstinence Syndrome is provided in Annexure B.

Medical termination of pregnancy should be offered, in case the client is not desirous of a child.

#### **CONSIDERATIONS WHILE PROVIDING OPIOID SUBSTITUTION THERAPY INTERVENTION TO A FEMALE INJECTING DRUG USER.—**

1. Special efforts must be made to make the female Injecting Drug User comfortable, as females are often reluctant to access services at places with predominant male Injecting Drug User clients.
2. The doctor and counsellor must ensure that the female Injecting Drug User is examined and interviewed in the presence of a female staff.
3. During assessment, enquiry must be specifically made regarding
  - a. Signs or symptoms of Sexually Transmitted Infection, as well as any high risk sexual behaviour
  - b. Last menstrual period to rule out pregnancy
  - c. Child-bearing history
  - d. Examination to rule out the presence of Sexually Transmitted Infection
4. Female Injecting Drug Users must be given priority during follow-up and dispensing of Opioid Substitution Therapy medicines and not-made to wait for their turn.
5. Presumptive Sexually Transmitted Infection treatment must be provided.
6. Contraceptives must be offered to those female Opioid Substitution Therapy clients in the child-bearing period and for those not desirous of having children.
7. Access to other psychosocial supportive services must be made available to those in need.
8. If the male partner is also an Injecting Drug User, efforts must be made to initiate the male partner on Opioid Substitution Therapy too.

## **Conclusions**

Opioid Substitution Therapy is an effective treatment option for opioid dependence as well as HIV prevention intervention for opioid dependent Injecting Drug Users. The clinical practice of buprenorphine-based Opioid Substitution Therapy is simple and can be delivered by physicians with adequate training. A proper assessment must be conducted, and screening for Opioid Substitution Therapy criteria must be done before initiating a client on Opioid Substitution Therapy. Buprenorphine is relatively a safer medicine to use. Appropriate client selection, an adequate dose of buprenorphine as well as for an adequate duration is an important determinant of a successful Opioid Substitution Therapy intervention. The attitude of staff towards the clients, combined with other issues such as dispensing hours of the clinic, provision of ancillary services are other important determinants of the success of Opioid Substitution Therapy intervention.

## References

1. Ambekar A, Goyal S. Pharmacological treatment of opioid dependence. In: Basu D, Dalal P (eds.) Indian Psychiatric Society Clinical Practice Guidelines for Substance Use Disorders.
2. Armstrong G, Kermode M, Sharma C, Langkham B, Crofts N. Opioid Substitution Therapy in Manipur and Nagaland, north-east India: operational research in action. *Harm Reduction Journal*. 2010, 7:29.
3. Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction— a treatment improvement protocol.
4. US Department of Health and Human Service, Substance Abuse and Mental Health Service Administration, Centre for Substance Abuse Treatment, 2004.
5. Connock M, et al. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. *Health Technology Assessment*, 2007; vol 11, No. 9.
6. Dhawan A, Jain R, Chopra A. Opioid substitution — Buprenorphine in India: A study report. United Nations Office on Drugs and Crime, Regional Office for South Asia, 2010.
7. Dhawan A, Jhanjee S. Manual for long-term pharmacotherapy. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, 2013.
8. Dorabjee J, Samson L. Self and community based opioid substitution among opioid dependent populations in the Indian sub-continent. *International Journal of Drug Policy*, 1998; 9: 411-416.
9. Effectiveness of drug dependence treatment in preventing HIV among Injecting Drug Users. World Health Organisation, 2005.
10. Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. World Health Organisation, 2009.
11. Kumar MS, Natale RD, Langkham B, Sharma C, Kabi R, Mortimore G. Opioid substitution treatment with sublingual buprenorphine in Manipur and Nagaland in Northeast India: what has been established needs to be continued and expanded. *Harm Reduct J*. 2009 Feb 26;6:4.
12. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*. 2008 Apr 16;(2):CD002207.
13. Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement for opioid dependence. *Cochrane Database Syst Rev*. 2009 Jul 8;(3):CD002209.
14. Metzger DS, Woody GE, McLellan AT, O'Brien CP, Druley P, Navaline H, DePhilippis D, Stolley P, Abrutyn E. Human immunodeficiency virus seroconversion among intravenous drug users in- and out-of-treatment: An 18-month prospective follow-up. *J Acquir Immune Defic Syndr*. 1993 Sep;6(9):1049–1056.
15. Operational guidelines for the management of opioid dependence in the South-East Asia region. World Health Organisation, Regional Office for South-East Asia, 2008.
16. Rao R, Ambekar A, Agrawal A. Opioid substitution therapy under National AIDS Control Programme – A situational Analysis. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences. Prepared for Global Fund Round 9 Injecting Drug User-HIV grant project 'Hifazat'.
17. Rao R, Ambekar A, Yadav S, Sethi H, Dhawan A. Slow-release oral morphine as a maintenance agent in opioid dependence syndrome: an exploratory study from India. *Substance use and misuse*, 2012; 17: 294–300.
18. Ray R, Dhawan A, Ambekar A. Implementing Opioid Substitution Therapy —A training manual for service providers.
19. National AIDS Control Organisation, Government of India, 2011.
20. Substance use disorders, Manual for physicians. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, 2013.
21. WHO or United Nations Office on Drugs and Crime or Joint UN Programme on HIV or AIDS position paper. Substitution maintenance therapy in the management of opioid dependence and HIV or AIDS prevention. World Health Organisation, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV or AIDS, 2004.



# Annexures

## Annexure A: Buprenorphine Interactions with Anti-Retroviral Medicines

Anti-retroviral medicine	Effect on buprenorphine	Buprenorphine effect on Anti-Retroviral Treatment medicine	Clinical considerations
<b>Nucleoside Reverse Transcriptase Inhibitors (NRTIs)</b>			
No major interactions: No dose adjustment required			
<b>Non- Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)</b>			
Efavirenz and Nevirapine	Reduced concentration of buprenorphine	No effect	Observation required; may need to <b>increase</b> dose of buprenorphine if opioid withdrawal symptoms or signs observed or reported
<b>Protease inhibitors</b>			
Atazanavir	Increased buprenorphine Effects	None	Observation required; may need to <b>decrease</b> dose of buprenorphine if opioid intoxication symptoms or signs observed or reported
Ritonavir, Saquinavir, Indinavir, Tipranavir	Potential for increased Buprenorphine effects	None	Observation required; may need to <b>decrease</b> dose of buprenorphine if opioid intoxication symptoms or signs observed or reported
<b>Integrase Inhibitors</b>			

No major interactions observed or reported.

## Annexure B: Neonatal Abstinence Syndrome

(Adapted from: Operational guidelines for the management of opioid dependence in the South-East Asia region, World Health Organisation, Regional Office for South-East Asia, 2008).

**CLINICAL FEATURES.**—Babies born to mothers on buprenorphine should be monitored after delivery. Specific assessment tools can be used to track the signs and symptoms of neonatal abstinence syndrome (NAS). Modified Finnegan Neonatal Abstinence Syndrome Score (NASS) can be used for this purpose. The scoring should be initiated two hours after birth and repeated every four hours. Pharmacological treatment is initiated when three consecutive scores average more than or equal to 8, or when two consecutive scores are more than or equal to 12.

Modified Finnegan Neonatal Abstinence Syndrome Score chart for term infants:

System	Signs	Score	Date and time
Central nervous system disturbances	High-pitched cry	2	
	Continuous high-pitched cry	3	
	Sleeps <1 hour after feeding	3	
	Sleeps <2 hours after feeding	2	
	Sleeps <3 hours after feeding	1	
	Mild tremors, disturbed	1	
	Moderate-severe tremors, disturbed	2	
	Mild tremors, undisturbed	3	
	Moderate-severe tremors, undisturbed	4	
	Increased muscle tone	2	
	Excoriation (specify area)	1	
	Myoclonic jerks	3	
	Generalized convulsions	5	

System	Signs	Score	Date and time
Metabolic or vasomotor or respiratory disturbances	Fever (37.3-38.3°C)	1	
	Fever (38.4°C and higher)	2	
	Frequent yawning (3-4 times in a row)	1	
	Nasal stuffiness	1	
	Sneezing (>3-4 times in a row)	1	
	Nasal flaring	2	
	Respiratory rate >60/min	1	
	Respiratory rate >60/min with retractions	2	
Gastrointestinal disturbances	Excessive sucking	1	
	Poor feeding	2	
	Regurgitation	2	
	Projectile vomiting	3	
	Loose stools	2	
	Watery stools	3	
Total SCORE			
Scorer's initials			

**TREATMENT.**—General nursing care should be provided. Keeping the baby warm, close contact with the mother, etc. should be provided to the baby.

**PHARMACOLOGICAL TREATMENT.—Opioids** are the preferred medicines of choice. Morphine elixir 1mg/ml can be used to treat Neonatal Abstinence Syndrome. Initiate with 0.02 mg/kg body weight orally at every 4 to 6 hour interval till the desired response. Maintain the same dose for 3 to 5 days, and then taper by 10% of the total dose every 2 to 3 days. Vital signs and oxygen saturation should be monitored during opioid-based treatment. Care should be taken not to induce opioid toxicity or overdose in the neonate due to administration of a higher dose of morphine. Morphine overdose may manifest as narcosis, poor reflexes, decreased suckling, and poor response to pain, and can lead to coma, decreased breathing, hypothermia and bradycardia. In such cases, respiratory support should be provided; naloxone should be avoided as it can cause withdrawal seizures.

**Sedatives** are the second choice for treatment of Neonatal Abstinence Syndrome. Control of symptoms and seizures are not as effective as with opioids. Phenobarbitone 5 mg/kg/day in two divided doses can be given.

The neonate should be hospitalised till 4 weeks of delivery along with the mother for complete recovery. Breastfeeding must be continued in the meantime.

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 683.**—मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 की उप-धारा (1) उपबंध करती है कि केन्द्रीय सरकार सामान्यतः उक्त अधिनियम के उपबंधों को कार्यान्वित करने हेतु, उक्त अधिनियम और उसके अधीन बनाए गए किन्हीं नियमों से संगत मार्गदर्शन बना सकेगी;

और उक्त धारा की उप-धारा (2), अन्य बातों के साथ-साथ, केन्द्रीय सरकार को एनएसीपी III परिचालन मार्गदर्शनों के अधीन लक्षित हस्तक्षेप —प्रवासी और ट्रक ड्राइवर के प्रयोजनार्थ परिचालन मार्गदर्शन बनाने के लिए सशक्त करती है;

अतः, अब केन्द्रीय सरकार मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए इस अधिसूचना से उपाबद्ध अनुसूची के अनुसार एनएसीपी III के अधीन लक्षित हस्तक्षेप (प्रवासी और ट्रक ड्राइवर) परिचालन मार्गदर्शन, 2018 अधिसूचित करती है।

[फा. सं. टी-11020/50/1999-नाको (पी एंड सी)]

आलोक सक्सेना, संयुक्त सचिव

New Delhi, the 14th August, 2020

**S.O. 683.**—Whereas sub-section (1) of section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017) provides that the Central Government may make guidelines consistent with the said Act and any rules made there under, generally to carry out the provisions of the said Act;

And where sub-section (2) of the said section, *inter alia*, empowers the Central Government to make guidelines for the purposes of the Targeted Interventions Under NACP III Operational Guidelines – Migrants and Truckers;

Now, therefore, in exercise of the powers conferred by section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017), The Central Government hereby notifies the Targeted Interventions Under NACP III (Migrants and Truckers) Operational Guidelines, 2018 as per the Schedule annexed to this notification.

[F. No. T-11020/50/1999-NACO(P&C)]

ALOK SAXENA, Jt. Secy.

## **SCHEDULE**

### **“Targeted Interventions Under NACP III MIGRANTS AND TRUCKERS”**

**OPERATIONAL GUIDELINES, 2018**

# FOREWORD

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The prevention of new infections in High Risk Groups is a major thrust in National AIDS Control Programme III. The most effective means of controlling the spread of HIV in India is through the implementation of Targeted Interventions (TIs) amongst persons most vulnerable to HIV or AIDS, such as female sex workers, Men Who Have Sex with Men and Transgenders and Injecting Drug User. In addition, the Bridge Populations of truckers and migrants also require focused interventions. Both National AIDS Control Organisation and the States place a high priority upon full coverage of the States' Female Sex Workers, Men Who Have Sex with Men or Transgenders, Injecting Drug Users and migrants or truckers with Targeted Interventions. In order to standardise the approach to scaling up coverage among these core groups and Bridge Populations and maintain a high level of quality, it is important to provide detailed information on various operational issues in Targeted Interventions.

National AIDS Control Organisation has prepared these Operational Guidelines after a series of consultations with Technical Resource Groups, representatives of civil society, Government, core groups, donors and other stakeholders. The guidelines describe the operational details of Targeted Intervention projects with various core High Risk Groups (Part 1) and Bridge Populations (Part 2). The guidelines also provide detailed information on issues related to programme management, services required in terms of human resources, infrastructure, linkages and Monitoring and Evaluation indicators for each programme area.

I take this opportunity to acknowledge the contribution made by the Technical Resource Groups, the Targeted Intervention Team of National AIDS Control Organisation and the National AIDS Control Organisation Technical Support Unit in preparing these guidelines. I would also like to acknowledge and thank the various agencies mentioned in the acknowledgments section for their valuable inputs.

We hope that these guidelines will help State AIDS Control Societies, potential partners (Non-Governmental Organisations, Community Based Organisations, and networks), programme managers and other staff working in Targeted Intervention projects and Technical Support Units to implement and manage Targeted Intervention projects more effectively.

Let the scale up challenge begin!

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**National AIDS Control Organisation Guidelines and Tools Referenced in these Guidelines**

Non-Governmental Organisation or Community Based Organisation Guidelines, March 2007

Guidelines on Financial and Procurement Systems for Non-Governmental Organisations or Community Based Organisations, March 2007

Targeted Intervention Costing Guidelines

Sexually Transmitted Infection Guidelines

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The following individuals and organisations are acknowledged for their work which is quoted or used in adapted versions in the text of the Guidelines and the Annexures:

**Migrants:**

- (1) Bill and Melinda Gates Foundation
- (2) CARE India
- (3) Department for International Development
- (1) Rabo Capital Securities Limited
- (4) India Health Action Trust, University of Manitoba
- (5) Population Services International
- (6) International Labour Organization

**Truckers:**

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- (iv) Amit Shrivastav, Targeted Interventions Team, National AIDS Control Organisation Technical Support Unit (Family Health International);
- (v) Meera Mishra, National AIDS Control Organisation Technical Support Unit (Constella Futures);

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15. Mr. T. K. Malhotra, Federation of Indian Automobile Association
16. Representative from Population Services International, New Delhi
17. Representative from Transport Corporation of India

## INTRODUCTION : MIGRANTS

The purpose of these guidelines is to ensure the delivery of quality HIV prevention interventions to high risk migrant populations in India. The guidelines outline standardised operating procedures for implementing comprehensive HIV prevention services for migrant populations.

These guidelines have been developed with the following audience in mind:

- (1) State AIDS Control Societies
- (2) Technical Support Units
- (3) Implementing partners (Non-Governmental Organisations or Community Based Organisations)

It is recommended that all organisations using these guidelines consider each of the proposed elements in the context of the organisation's current environment and other relevant guidelines such as *Non-Governmental Organisation or Community Based Organisation Guidelines*, National AIDS Control Organisation, March 2007 and *Guidelines on Financial and Procurement Systems for Non-Governmental Organisations or Community Based Organisations*, National AIDS Control Organisation, March 2007.

## CHAPTER 1

### Introduction to Targeted Interventions for Migrants Under National AIDS Control Programme III

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## 1.1 RATIONALE FOR TARGETED INTERVENTIONS AMONG MIGRANTS:

### 1.1.1 Role of Migration in HIV Transmission

An important source of HIV related vulnerability is mobility and migration, mobility being defined as a change of location and migration being defined as a change of residence.

India, home to the third highest number of HIV positive people in the world, is characterised by widespread and fluid migration and mobility. More than 2 million Indians do not live in the place of their birth. While mobility in other parts of the world is inhibited by national boundaries, there are few land masses the size of India with such a good transport infrastructure as this country.

Once migrants reach their destination, language and other difficulties lead to feelings of discontinuity and transition that enhance loneliness or sexual risk taking. Such risk taking may be reinforced by a lack of HIV or AIDS awareness, information and social support networks at both source and destination points, which cumulatively contribute to a migrant's vulnerability.

Back home, spouses of migrants are also vulnerable to HIV if their husbands return on a regular basis and have become infected with HIV. Some wives also have their own sexual networks during their husband's absences.

It is important to note that not all migrants are at equal risk of HIV. It is those men who are part of sexual networks at their destinations – either with Female Sex Workers or with other men (Men Who Have Sex with Men) or Transgenders – who are more prone to HIV infection. Similarly, those female migrants who take up transactional sex at destination locations are at greatest risk of HIV.

### 1.1.2 Definition of Migrants for Targeted Intervention Purposes

Classification of migrants from an HIV vulnerability perspective is based on the following key criteria:

- (a) Intersection with high risk sexual networks;
- (b) Pattern, degree and duration of mobility and migration;
- (c) Age;
- (d) Whether moving singly or with family;
- (e) Route of migration;
- (f) Destination of migration.

Based on these criteria, the definition of migrants is:

**Single men and all women in the age group of 15 to 49 years who move between source and destination within the country once or more in a year.**

Those who return to their source location at regular intervals are called “circular migrants”.

### DEFINITION OF MIGRANTS FOR TARGETED INTERVENTIONS UNDER NATIONAL AIDS CONTROL PROGRAMME III

**From an HIV programming perspective under National AIDS Control Programme III, migrant Targeted Interventions:**

- (a) Are **destination interventions for in-migrants** (i.e. at the point of destination) and not at the source
- (b) Are to focus on **high risk migrant men and women** (i.e. those who are part of high risk sexual networks, either as clients of sex workers and high risk Men Who Have Sex with Men, or as sex workers themselves).



**Note: Interventions at the “source” villages or towns or States (i.e. for “out-migrants”) do not fall under Targeted Interventions for migrants; if at all, they are covered under other schemes (e.g. Link Workers).**

### 1.1.3 Significance of the Bridge Population in HIV Epidemics:

The broader transmission of HIV beyond High Risk Groups (which include Female Sex Workers, Men Who Have Sex with Men and Transgenders, Injecting Drug Users) often occurs through their sexual partners, who also have lower risk sexual partners in the “general” population.

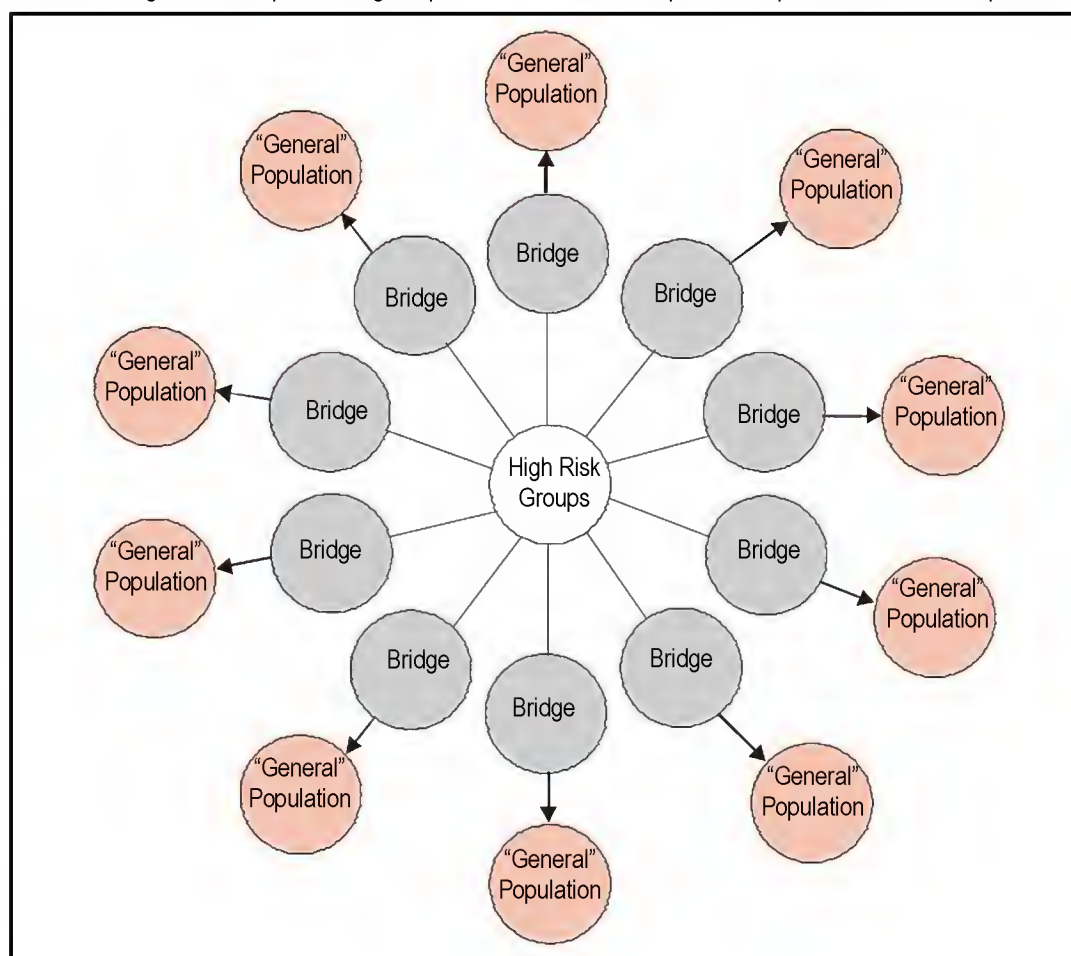
- (a) For example, a client of a sex worker might also have a wife or other partner who is at risk of acquiring HIV from her higher risk partner;
- (b) And a migrant woman who engages in sex work at her destination point may return to her spouse or partner at home, putting him at risk of HIV infection.

Individuals who have sexual partners in the highest risk groups as well as other partners of lower risk (general population) are called a “Bridge Population”, because they form a transmission bridge from the key population to the general population.

**Men are an important Bridge Population in HIV epidemics for several reasons:**

- (a) Men are more likely to have multiple partners than women;
- (b) Men influence the ‘demand’ side of sex work which determines the size and distribution of sex worker populations at destinations.

This is illustrated in Figure 1.1. In this pattern of epidemic transmission, it is most effective and efficient to target prevention towards the High Risk Group and Bridge Population members to keep their HIV prevalence as low as possible.



**Figure 1.1 Illustration of an HIV Transmission Network**

High risk migrants who are targeted through Targeted Interventions are thus either in the Bridge Population category– that is as clients of High Risk Group members (e.g. Female Sex Workers, Men Who Have Sex with Men, Injecting Drug Users) – or are High Risk Group members themselves (as Female Sex Workers, Men Who Have Sex with Mens or Injecting Drug Users). Migrant interventions will focus on providing services to bridge population high risk men. Any migrant identified as an High Risk Group member can be referred to the nearest.

Targeted Intervention for that risk group.

#### 1.1.4 Sources of Risk and Vulnerability for Male Migrants

- (a) Relative freedom in the new setting as well as peer pressure to experiment with new norms;
- (b) Distress migration driven by seasonal drought or disasters;
- (c) Loneliness, drudgery and long periods of separation from spouse or sexual partner;
- (d) Having disposable income, clubbed with limited choices for affordable entertainment and recreation. This usually means drinking and, sometimes, drugs as well as sex with Female Sex Workers and other casual sex relationships.

#### 1.1.5 Sources of Risk and Vulnerability for Female Migrants

- (a) Poverty (usually reason for migrating in the first place) makes women more vulnerable to being pushed in to sex work at their destination to supplement their earnings;
- (b) Lack of HIV and AIDS awareness, information and social support networks at both source and destination points;
- (c) Loneliness, drudgery and long periods of separation from family or spouse or sexual partner;
- (d) Limited or no skills to cope with the overall pressures and environment at destination places. This may lead to behaviours associated with risk for HIV infection, i.e. drinking and sometimes drugs as well as sex with male colleagues, casual sex relationships or sex work;
- (e) Risk of being trafficked along the way and the risk of sexual exploitation, violence or harassment by sexual network operators or local power structures or by colleagues or supervisors or contractors in the workplace;
- (f) Lack of knowledge and negotiation skills make it difficult for women to negotiate condom use with their husbands and other sexual partners;
- (g) Lack of decision making power and reticence about seeking Sexually Transmitted Infection treatment often lead to a suppressed demand for health services even when the need is obvious. This results in prolonged untreated Sexually Transmitted Infections and increases the risk of HIV infection;
- (h) Lack of awareness of policies and laws which promote women's rights to reproductive and sexual health and equal access to education and information on health care.

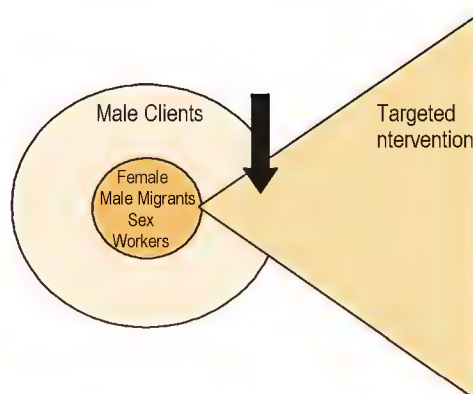
## 1.2 CONSIDERATIONS FOR MIGRANT PROGRAMMING:

### 1.2.1 Targeting High Risk Migrant Men:

India's male migrant population is very large and diverse, and since only a small proportion can be reached with HIV programmes the focus should be on those at highest risk.

Figure 1.2 illustrates two main strategic issues:

- (a) First, **only a proportion of all sex worker clients are migrants**. This proportion will vary by location.
- (b) Second, **most migrants are not clients of sex workers (either Female Sex Workers or high risk Men Who Have Sex with Men)**.



**Figure 1.2. Population Approach to Targeted Interventions for Migrant Men**

Therefore, the emphasis of the Targeted Intervention strategy for male migrants should be on the subset of men who are both migrants and part of high risk sex networks, usually as clients of Female Sex Workers or of high risk Men Who Have Sex with Men.

Since many men who have sex with Female Sex Workers, high risk Men Who Have Sex with Men and Transgenders also have other partners, both male and female, focused interventions for these Bridge Populations are strategically critical to controlling the HIV epidemic.

This focused intervention approach is indicated in Figure 1.2. This approach ensures that the intervention is cost-effective, since resources will be directed to where HIV prevention is most critical.

This approach requires the gathering of strategic information on both the location of large concentrations of male migrants and their interaction with local Female Sex Workers or high risk Men Who Have Sex with Men as clients, or in the case of female migrants, their participation in transactional sex.

Mapping exercises (see Chapter 2 below) can identify the confluence of migrant men with High Risk Group networks to keep interventions focused on those migrant men who are actually at risk and on the locations where risk occurs.

### 1.2.2 Targeting High Risk Migrant Women

As discussed above, female migrants are largely at risk due to the possibility of engaging in transactional sex, either through coercion or to supplement their income. To that extent, high risk migrant women are entitled to receive the same package of services as female sex workers. The needs assessment conducted at the start of the project should share information on known high risk female migrants with the closest Non-Governmental Organisation implementing Targeted Interventions for female sex workers so the Non-Governmental Organisation can plan to include them in services.

### 1.2.3 Linking Migrants at Source and Destination Points

In spite of the fact that migration is a continuum with different stages – source, transit, and destination point – the bulk of HIV related migration programming is directed as Targeted Interventions towards migrants in their urban destinations. As a result, where migrants come from, how they travel and the situation of their families left behind remain largely unaddressed by stand-alone destination-based interventions. This means that migrants' emotional, social and support needs before departure, during travel, and in the destination State/s are difficult to meet. Destination-based programmes often have Outreach Workers who speak different languages and have different cultural backgrounds.

There is therefore a strong need and a rationale for establishing effective linkages between source and destination programmes. An engaged source State can motivate and support destination States to address specific migrant sub-populations under their HIV prevention and care programmes, e.g. Rajasthani or Bihari or Gujarati or Kannada migrants. Based on the mapping data from destination States (shared with the source State AIDS Control Society by the destination State AIDS Control Society), the State AIDS Control Society should take the responsibility of covering migrant wives or sexual partners, through link workers and as part of broader State AIDS Control Society -supported HIV or AIDS initiatives in the major pockets of high outward migration.

Such links between source and destination programmes are most efficiently established through a Memorandum of Understanding between the State AIDS Control Society of the destination and source States (an Memorandum of

Understanding may be signed between two State AIDS Control Society or a group of State AIDS Control Society). An Memorandum of Understanding provides a constructive framework for HIV prevention intervention by developing a coordination mechanism assuring the required support for the interventions. See Paragraph 2.2.2.B for more information.

#### 1.2.4 Intervention Package for High Risk Migrants Covered under Targeted Interventions

The intervention package for high risk migrants is outlined below and detailed further in the operational guidelines.

##### Outreach and Communication

Peer-led, Non-Governmental Organisation -supported outreach and Behaviour Change Communication

- (a) Differentiated outreach based on risk and typology;
- (b) Large-group format activities (e.g. street theatre, games, etc.);
- (c) Interpersonal Behaviour Change Communication.

##### Services

- (a) Promotion of condoms;
- (b) Linkages to Sexually Transmitted Infection (sexually transmitted infection) services and other health services (e.g. Integrated Counselling and Testing Centre, Antiretroviral Therapy, drug or alcohol de-addiction);
- (c) Strong referral and follow-up system.

##### Enabling Environment

- (a) Advocacy with key stakeholders or power structures;
- (b) Linkages with other programmes and entitlements.

##### Community Mobilisation

- (a) Building capacity of migrant groups to assume ownership of the programme;
- (b) Project centres.

## CHAPTER 2

### Operationalising Targeted Interventions for Migrants: Guidelines for State AIDS Control Society and Technical Support Unit

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Estimating the extent and nature of HIV risks and vulnerabilities among migrants through mapping

- (a) Review of existing data sources
- (b) Risk assessment study
- (c) Supplemental mapping



Recruitment and capacity building

- (a) Contracting Non-Governmental Organisations or other implementing agencies
- (b) Roles of partner agencies
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## 2.1 MAPPING MIGRANT COMMUNITIES – GEOGRAPHIC MAPPING, SIZE ESTIMATION AND SITE ASSESSMENT

### 2.1.1 Identifying Intervention Areas



## A. Step 1: Review and analysis of existing data sources

This is done through a state-level analysis to locate large pockets of migrants, and a risk assessment study to ascertain if there are significant numbers who are at risk for HIV.

### Data analysis

Analyse data from National Sample Survey, Census and National Commission of Rural Labour to map major pockets of migrants in the state, where there are 5,000-10,000 single-male circular migrants (as defined in Paragraph 1.1.2 above) living within a radius of 5-10 kilometres. This process should be undertaken by the State AIDS Control Society of the destination states. The review and analysis should be shared with the potential partner agencies to facilitate their understanding and enable them to move on to the next stage.

### Risk assessment study

Contract an agency (preferably a local one and backed by Technical Support Unit) to conduct a risk assessment study to decide if these migrants are at risk based on the following criteria:

1. Had sex with a non-regular partner in the last 12 months
2. Different types of sexual partners for the risk population
3. Profile of risk population
4. Condom-related indicators
5. Proportion who suffered from Sexually Transmitted Infections in the last 12 months
6. Proportion who sought treatment from a qualified practitioner for Sexually Transmitted Infections
7. Proportion who feel it is important to know HIV status
8. Proportion who intend to get themselves tested
9. Proportion who feel at high risk with a female partner if they have sex in exchange for money or in kind
10. Proportion who have correct knowledge about the modes of HIV transmission

**Annexure 1, Risk Assessment** provides details on the types of interviews conducted, sample size, etc. This exercise will provide details as to which “slums” or “migrant areas” require intervention, if any.

**Unless the risk assessment study finds that the population in a given area is at GREATER risk than the average male population (defined in terms of the criteria above), there is no need for a Targeted Intervention there.**

For example, the National Behavioural Surveillance Survey 2001 indicates that ~10% of Indian men have had sex with a non-regular partner in the last 12 months. For migrant interventions to be necessary for a given population, this percentage must be much higher – e.g. in Dharavi this figure was >40% (according to a survey by Population Services International).

## B. Step 2: Supplemental mapping

When no information exists, or it is not available through the state-level analysis of large pockets of migrants, a mapping and situation assessment should be conducted with the following considerations in mind:

- (i) **Geographic approach** – High risk sexual networking is often geographically clustered and is frequently linked directly to a range of vulnerable populations including migrants. Mapping should therefore

identify priority locations for initiating and scaling up Targeted Interventions for all vulnerable populations. Moreover, this information should be augmented by a comprehensive situation and needs assessment for the local planning of supportive services such as condom promotion, voluntary counselling and testing, Sexually Transmitted Infection services and care, treatment and support. By prioritising locations, the full range of prevention, care and support services can be clustered more appropriately to enhance efficiencies and integration of programme components needed for any migrant intervention.

- (ii) **Need to focus on large “catchment” areas for efficient programming** – Migrant programmes at destination should cover geographic areas which contain concentrations of migrant populations in conjunction with sex work concentration. It is therefore important to map pockets or villages or slums which have a high concentration of circular migrants (as opposed to relocated migrants) and overlay this mapping on sex worker concentration data from Targeted Interventions with Female Sex Workers.

The emphasis of the mapping exercise for migrant Targeted Interventions should be on identifying migrant men and women who form a part of high risk sexual networks, usually as clients of sex workers or high risk Men Who Have Sex with Men or Transgenders or as practising sex workers themselves.

Mapping focuses on **three kinds of intervention sites**:

- (a) Hotspots (points of sex solicitation);
- (b) Prioritised industry or workplace centres;
- (c) Large residential centres.

A dual-layer location mapping (**preliminary and detailed**) is required to identify sub-pockets of risk within larger locations and to gather information for intervention purposes.

### **Preliminary mapping (identifying sub-pockets of risk)**

Preliminary mapping provides a general overview of the entire geographic area and is the basis for the refined methods and tools necessary for a detailed mapping study. Mapping is to be done by Outreach Workers who are given training in the methodology, preferably by Technical Support Unit by an agency hired by State AIDS Control Society. Preliminary mapping will include a **geographic area overview** and **interviews with Key Informants** to help identify:

- (i) Congregation points of high risk men
- (ii) Presence of sex workers
- (iii) Presence of elements such as video parlours, youth clubs or mandals, Non-Governmental Organisations, temples, hotels, lodges, bars and movie theatres that could be vantage points for target-efficient field communication

The Key Informants in each area include shopkeepers, cinema hall employees, slum residents, housing colony residents, slum development officers, municipal corporation officers, private doctors, government hospital doctors, Non-Governmental Organisations, industry employers and employees, labour contractors, bar owners and clientele, railway station masters and bus depot in-charges.

**See Annexure 2, Mapping Methodology and Annexure 3, Preliminary Mapping.**

### **Detailed mapping (identifying locations and populations for intervention)**

Detailed mapping is needed in order to ensure a target-efficient, streamlined intervention among migrant workers. This study will:

- (i) Assess the target group size of high risk migrant men and women
- (ii) Identify target-efficient hotspots or strategic locations
- (iii) Determine possible range of communication activities to be conducted at the identified hotspots
- (iv) Assess the presence of sex workers in the area along with the type of sex work and the typology of the sex workers

The detailed mapping study will be done by Outreach Workers, preferably trained by the Technical Support Unit or an agency hired by the State AIDS Control Society, using three primary components:

1. A **detailed mapping tool** that provides information on target group size as well as congregation points of high risk men and women (**see Annexure 4, Detailed Mapping**).
2. An **Female Sex Workers assessment** that provides information on sites of sex work as hotspots for field communication activities and services (**see Annexure 5, Female Sex Workers Assessment**).
3. A **screening of mandals or youth clubs and video parlours or other sites** that provides information on high risk men and women who are part of sexual networks. Also the potential types and frequency of field communication activities (**see Annexure 6, Hotspot Screening (Owners) and Annexure 7, Hotspot Screening (Patrons)**).

### Understanding source areas for migrants

While conducting mapping at the destination sites, an attempt should be made to identify source States, including the details of village or town or District clusters. This information should be communicated to the State AIDS Control Society of the source State to facilitate outreach to the migrant spouses or sexual partners back home and to returning migrants. See Paragraph 1.2.3 for more information.

#### Tools

- Annexure 1** *Risk Assessment*
- Annexure 2** *Mapping Methodology*
- Annexure 3** *Preliminary Mapping*
- Annexure 4** *Detailed Mapping*
- Annexure 5** *Female Sex Workers Assessment*
- Annexure 6** *Hotspot Screening (Owners)*
- Annexure 7** *Hotspot Screening (Patrons)*

## 2.2 RECRUITMENT AND CAPACITY BUILDING

### 2.2.1 Contracting Non-Governmental Organisations for Targeted Interventions

Non-Governmental Organisations and other implementing agencies (e.g. unions, registered youth groups) will be contracted to implement Targeted Interventions for a population of at minimum 5,000 migrants.

Non-Governmental Organisations or other implementing agencies should be selected and contracted based on the mapping and situation assessment findings and National AIDS Control Organisation's *Non-Governmental Organisation or Community Based Organisation Guidelines*. Preference may be given to Non-Governmental Organisations or organisations that are already working with migrant communities in urban slum areas on other issues (such as water and sanitation, other basic urban services health, literacy or education, etc.), since they have familiarity and access to migrants and have gained their trust.

The Non-Governmental Organisation is to hire staff as per the following ratios:

- (a) Volunteer Peer Leaders at a ratio of 1 Volunteer Peer Leader to 100 migrants;
- (b) Outreach Workers at a ratio of 1 Outreach Worker to 10 Volunteer Peer Leaders;
- (c) Communication team(s) (street theatre or play teams);
- (d) Coordinator at a ratio of 1 coordinator to 5 Outreach Workers;
- (e) One part-time doctor for clinic;
- (f) One counsellor;
- (g) One part-time accountant.

The Outreach Workers and Volunteer Peer Leaders will receive proper induction training covering all aspects and components of migrant programming, including the social marketing of condoms. The details of capacity building needs and

planning for the same are described in Paragraph 3.1.2.D (refer also to Section 8 of the *Non-Governmental Organisation or Community Based Organisation Guidelines*, National AIDS Control Organisation, March 2007).

The following table summarises the coverage and personnel or volunteers ratio under a migrant Targeted Intervention:

Migrant Coverage	Volunteer Peer Leaders: Migrants	Outreach Workers: Volunteer Peer Leaders
5,000 Migrants (minimum unit for the migrant Targeted Intervention)	1:100 50 Volunteer Peer Leaders for coverage of 5,000 Migrants	1:10 5 Outreach Worker for coverage of 5,000 Migrants

## 2.2.2 Roles of Partner Agencies

### A. National AIDS Control Organisation

- Advocate with key funding sources to ensure that all infrastructure development projects incorporate a clause for construction and other contractors to provide HIV or AIDS prevention and referral services (as was done in the case of certain projects implemented by the World Bank or Asian Development Bank); Dialogue with Labour Department or Ministry for systematic data collection on migration (as part of the larger mainstreaming agenda with the Labour Department or Ministry);
- Through Panchayati Raj Institutions, facilitate the active maintenance of the “migration register” at village level. This can be done at all Panchayats;
- Coordinate information sharing between State AIDS Control Society to enable coverage of known source locations through link workers.

### B. State AIDS Control Society

#### Advocacy with Government departments

Government departments play a critical role in both service provision and addressing the underlying causes of distress migration. Safe migration is a factor of informed choice. Much is being done for provision of information on HIV or AIDS, safe sex, available services, etc., but very little on improving choices for migrants, especially in the source areas. Based on mapping of high out-migration areas, State AIDS Control Society must advocate with concerned government departments to implement programmes for livelihoods, self-employment, micro-credit, vocational training, etc. in line with their comparative strengths. This could include government departments such as Panchayati Raj Institution, Rural Development, Horticulture, Khadi and Gramodyog, Department of Women and Child, Education (vocational and skill based), etc.

#### Advocacy for workplace policies and programmes

As per National AIDS Control Organisation's letter issued to all State AIDS Control Society in April 2006, State AIDS Control Society should link with small- and large-scale employers of migrants to advocate for workplace policies and programmes (**see Annexure 8, HIV or AIDS Workplace Policies**). A large number of industries or workplaces engage migrant workers as regular and part-time workers. These may include clusters of small industries or workplaces (e.g. Pimpri Chinchwad near Pune, Wazirpur and Bhwari near Delhi) or large industrial houses such as Jindals, Reliance, Jubilant Organosys which are located in remote areas and require workers to migrate to those locations on a short-term basis.

While the large industries or workplaces have a Corporate Social Responsibility strategy, few of them include HIV or AIDS in this. Possible actions with medium and large industries or workplaces include:

- Development and implementation of workplace policies to protect their workforce from HIV or AIDS and provide care and support to those infected;
- Advocacy to include HIV or AIDS services into their Corporate Social Responsibility strategy, including provision of outreach, prevention and care services in their catchment areas. Best-practice examples of HIV or AIDS policy for the workplace from Gujarat Ambuja and TCIL are included in Annexure 8. For smaller industries or workplaces, activities will include:
- Mapping of industry or workplace clusters (with initial cues from business organisations such as Rotary and Lions Clubs which have membership from smaller industries or workplaces);



- (d) Advocating with senior management of these workplaces to undertake sensitisation of workers;
- (e) Since most of the workers in smaller industries or workplaces are temporary, there is much less commitment towards workers' welfare. An alternative plan is to contract Non-Governmental Organisations to run awareness programmes for the workers (e.g. HIV & YOU model of United Nations Development Programme);
- (f) Establish referral linkages with public and private sector providers for Sexually Transmitted Infection, Integrated Counselling and Testing Centre, care, and treatment services.

### Linking programmes in destination and source State AIDS Control Society

A Memorandum of Understanding between State AIDS Control Society provides a perfect structure for the pooling of information and resources. This is beneficial to both states and helps reach those at most risk at both source and destination, for example, in-migrants and their sexual partners in the destination State, and returning migrants and their sexual partners in the source State. The data of migrant mapping at the destinations will also provide information on the migrants' source States or regions or Districts or Blocks. This information should be shared with the source State to facilitate outreach to returning migrants and to their spouses or sexual partners back home. At the same time, Outreach Workers who speak the migrants' own language and dialects may be provided to the destination States from the source State (through State AIDS Control Society or Non-Governmental Organisations). Further advantages of this strategy include:

- (a) **A linked programme enables a holistic approach** that includes both migrant and spouse or sexual partner and the extra-marital relationships of both. Outreach to migrant spouses can be done through the ongoing HIV prevention and care programmes in the source state by engaging link workers and community-based structures;
- (b) **Linked programming provides a framework for understanding the complete context within which migration operates:** the push factors of out-migration, the cycle of leaving and returning, the flow of funds, sexual networking at destination and source, and the living and working environment of migrants at destination. Linked programming provides vital and powerful information with regard to the nature of HIV risk and vulnerabilities in both destination and source States;
- (c) **Facilitating assessment of impact of migrant interventions:** Since migrant interventions under National AIDS Control Programme III are designed and executed at destination locations, source states can collect and provide information to monitor and evaluate the degree of success of these interventions (particularly on health seeking behaviours, condom use by returning migrants with spouses or sexual partners at home and some of the proxy indicators of reduced vulnerability of migrants going out). Again, this will be done through the ongoing HIV prevention and care programmes in the source State by engaging link workers and community-based structures;
- (d) **Integrate HIV into ongoing work of Non-Governmental Organisations:** Integrating HIV interventions into the ongoing work of Non-Governmental Organisations rather than having stand-alone initiatives can be an effective strategy to address issues of basic human rights, including the rights of migrants or workers at destination and issues of stigma and discrimination. In addition, establishing links with other government programmes that benefit migrants in both source and destination States can facilitate the realisation of their rights and entitlements, reduce their vulnerabilities and improve their overall quality of life;
- (e) **Communication material sharing:** A linked programme provides the cultural affinity that is necessary for providing support to "strangers in a strange land". For example, Information, Education and Communication or Behaviour Change Communication materials in the migrant's home language can easily be obtained from the source States.

### Engage industry or workplace institutions, employers' associations, other allied organisations and structures

These stakeholders should be engaged to develop and implement policies that reduce the vulnerability of migrants and promote accessibility of services. They could follow the same guidelines for a workplace policy as described in Paragraph 2.2.2.B. Key responsibilities at this level include:

- (a) Development of healthy workplace policies for migrants that reduce their vulnerability to HIV;
- (b) Incorporation of education programmes for migrant labourers at an early stage of induction into the industry to provide them with perspectives, information and skills to reduce their HIV-related vulnerability and risk.

### C. Non-Governmental Organisations and other implementers (including workplace Non-Governmental Organisations)

- (a) Identification of migrant pockets;
- (b) Being part of State AIDS Control Society programme;
- (c) Hiring of project staff;



- (d) Mainstreaming activities;
- (e) Monitoring of projects;
- (f) Community development and empowerment;
- (g) Local advocacy programme.

#### D. Other government departments

- (a) Sharing information and knowledge on migrant population;
- (b) Integration of HIV or AIDS programme in ongoing interventions.

#### E. Core group targeted intervention partners

- (a) Working with sexual partners of migrant population
- (b) Coordination with Non-Governmental Organisation implementing programme and Social Marketing Organisation

#### F. Social marketing organisations

- (a) Coordination with migrant Targeted Intervention implementing partners;
- (b) Provision of condom supply and chain management for Targeted Intervention;
- (c) Capacity building of Non-Governmental Organisation project staff and Volunteer Peer Leaders in condom promotion.

#### G. Other development agencies

- (a) Mainstreaming HIV or AIDS through network-based approach;
- (b) Meeting other needs of migrant population through resource provision;
- (c) Coordination with Non-Governmental Organisation implementing Targeted Intervention project;
- (d) Sharing knowledge, resources and skills for community development.

#### H. Summary table

The following table summarises the overall role of each agency in setting up migrant Targeted Interventions:

Steps in Intervention	Actions and Agency Responsible						
	National AIDS Control Organisation	State AIDS Control Society or Technical Support Unit	Non-Governmental organisations and Other implementers	Other government departments	Core group Targeted Intervention partners	Social Marketing agencies	Other development agencies or State AIDS Control Society at source
(1) Desk review of existing information		(1) Hire consultants or agency (2) Compile data (3) Database preparation	(1) Provide available information	(1) Provide available information	(1) Provide available information		(1) Provide available information
(2) Supplemental Mapping if required	(1) Develop standardised protocol (2) Resource allocation	(1) Hire consultants or agency (2) Develop Terms of Reference (3) Monitor mapping studies	(1) Facilitate mapping in respective geographic area	(1) Provide available information	(1) Provide available information		(1) Provide experts (2) Share experience of similar exercises in other programmes
(3) Selection of partners (Non-Governmental Organisation, Corporate houses, Social Marketing Organisations)	(1) Guidelines for partner selection	(1) Advertise for project allocation (2) Develop guidelines and appraisal system	(1) Implement projects	(1) Provide information on good agencies	(1) Implement projects	(1) Coordinate with Non-Governmental Organisations	(1) Provide list of networks of Non-Governmental Organisations
(4) Contracting Non-Governmental Organisation	(1) Develop protocol for contracting	(1) Develop contracts (2) Monitor contracts					
(5) Orientation of		(1) Provide	(1) Participate in	(1) Provide	(1) Share	(1) Provide	(1) Provide

Steps in Intervention	Actions and Agency Responsible						
	National AIDS Control Organisation	State AIDS Control Society or Technical Support Unit	Non-Governmental organisations and Other implementers	Other government departments	Core group Targeted Intervention partners	Social Marketing agencies	Other development agencies or State AIDS Control Society at source
Project team by State AIDS Control Society or Technical Support Unit		technical support and expertise  (2) Develop capacity building plan	capacity building exercise's	resource persons and material	experience and information on migrants clients and networks	resource persons and material	information on different approach of community participation, resource mobilisation
(6) Stakeholder advocacy	(1) Advocacy with central government department	(1) Hire experts for developing framework	(1) Identify stakeholders  (2) Advocacy programme implementation	(1) Facilitate linkages and programme mainstreaming  Allocate resources	(1) Implement	(1) Facilitate	(1) Mainstreaming linkages HIV or AIDS in other developmental programmes
(7) Provision of services	(1) Guidelines for service provision (2) Resource Allocation	(1) Channel programme services					
(8) Ongoing capacity Building	(1) Document and share experience at national level	(1) Develop plan, resource mobilisation and monitoring, networking	(1) Participate in programmes and feedback on usefulness of programmes (2) Suggest non conventional ways of capacity building (3) Mentor new organisation				
(9) Reporting	(1) Uniform reporting system development	(1) Establish and develop system (2) Monitor the system (3) Revision of the system	(1) Follow system (2) Monitor programme based on system	(1) Establish formal system of reporting of activities implemented for HIV or AIDS	(1) Follow system (2) Monitor programme based on system	(1) Share The activities undertaken	(1) Share the activities undertaken
(10) Monitoring		(1) Set state-level programme indicators	(1) Develop internal system of project monitoring				
(11) Evaluation	(1) Mid-term evaluation of programme	(1) Contract Agencies (2) Develop protocol					

Refer also to Section 11 ("Who will do what?") of *Non-Governmental Organisation or Community Based Organisation Guidelines*, National AIDS Control Organisation, March 2007.

### Tools

#### Annexure 8 Model HIV or AIDS Workplace Policies

#### National AIDS Control Organisation Non-Governmental Organisation or Community Based Organisation Guidelines

**2.2.3 Capacity Building**

Capacity building inputs at all levels of implementation, i.e. State AIDS Control Society, Non-Governmental Organisations and industrial centres or workplaces, other government departments, service providers, project staff and Volunteer Peer Leaders should be planned for effective Targeted Interventions for migrant population. The capacity building inputs should include:

- (a) Training;
- (b) Exposure visits;
- (c) "Handholding" or mentoring;
- (d) Knowledge- and experience-sharing workshops.

Themes for Capacity Building	Agencies Responsible			
	SACS	TSU	NGO	Industry
Basic information on HIV and STIs		X	X	X
Community development and strategies for personal development and empowerment of communities			X	
Human rights and violence	X	X	X	X
Community participation and empowerment			X	X
HIV testing and counselling	X	X		
BCC and development of IEC materials		X	X	
Peer education and community outreach			X	X
STI management	X	X	X	X
Condom programming	X	X	X	X
Safer sex negotiation		X	X	
Sex and sexuality		X	X	
Advocacy	X	X	X	X
Dealing with myths and misconceptions			X	X
National AIDS Control Programme III & Targeted Intervention Programme	X			
Reporting systems (CMIS)	X	X		
Project management		X		
Resource mobilisation		X	X	
Counselling		X	X	
Syndromic management of STIs	X	X		

### A. Linkages with other HIV programmes

In addition to HIV-specific technical areas, project staff should acquire more general skills enabling them to implement and manage interventions, such as conducting assessments, project planning, budgeting, Monitoring and Evaluation.

Different departments within State AIDS Control Society should work in coordination with each other. In the rapidly changing environment of HIV, their training requirements may vary. These may include the following issues:

- (a) Structures, policies and procedures;
- (b) Good governance, management and decision making;
- (c) Management information systems and institutional learning;
- (d) Critical analysis and strategic thinking;
- (e) Human and financial management systems;
- (f) External relations and partnership building;
- (g) Resource mobilisation.

### B. Capacity building approaches

Conventional and non-conventional capacity building approaches should be encouraged at all levels.

#### At State AIDS Control Society level

- (a) Capacity building needs assessment for the State;
- (b) Generation of capacity building resource pool of institutions and individuals;
- (c) Development of training modules;
- (d) Establishment of a regular capacity building input monitoring system;
- (e) Interstate
- (f) Memorandum of Understandings and sharing of knowledge and resources.

#### At implementing agency level

- (a) Regular training programmes for mainstreaming HIV or AIDS intervention in other developmental programmes;
- (b) Community development training programmes and activities.

## CHAPTER 3

### Implementing Targeted Interventions for Migrants: Guidelines for Non-Governmental Organisations

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### 3.1 STEPS IN IMPLEMENTATION

#### 3.1.1 Step 1: Stakeholder Analysis

Stakeholder Analysis is the identification of a project's stakeholders and the assessment of their interests and the ways in which these interests affect the programme's risk and viability. It is conducted as part of an overall needs assessment (and the overall process is hence often referred to by the acronym NASHA). The Stakeholder Analysis:

- (a) Identifies ways of harnessing the support of those in favour of the intervention;
- (b) Manages the risks posed by stakeholders who oppose the intervention;
- (c) Identifies the specific role that a particular stakeholder can play to achieve the intervention's objectives.

#### A. Objectives

The overall objective of Stakeholder Analysis is to ensure the participation of stakeholders at various levels of the intervention for reaching the desired project impact and sustaining the desired changes. Stakeholder Analysis has the dual benefit of interaction and rapport-building with the community when collecting information, while at the same time contributing to partnership in programme implementation.

More specifically, an Stakeholder Analysis will help to:

- (a) Identify and draw out the interests of stakeholders in relation to the issues the programme is seeking to address;
- (b) Capture local behaviours and perceptions within the intervention site that will allow more accurate and effective communication activities to be designed;
- (c) Identify conflicts of interests between stakeholders which will influence the impact of the project and manage these in such a way that maximum positive involvement is achieved from various stakeholders;
- (d) Identify relations between stakeholders which can be built upon, and enable strategic alliances of sponsorship, ownership and cooperation;
- (e) Help to assess the appropriate type and role of participation by different stakeholders at successive stages of the project cycle;
- (f) Identify the underlying causes of poor health among the target group and develop strategies in a participatory way to address them;
- (g) Develop an enabling environment to sustain the desired positive behaviour changes introduced by the programme;
- (h) Identify and promote the formation of community stakeholder groups and potential Volunteer Peer Leaders.

The place of Stakeholder Analysis within the context of mapping and planning is seen in Figure 3.1.

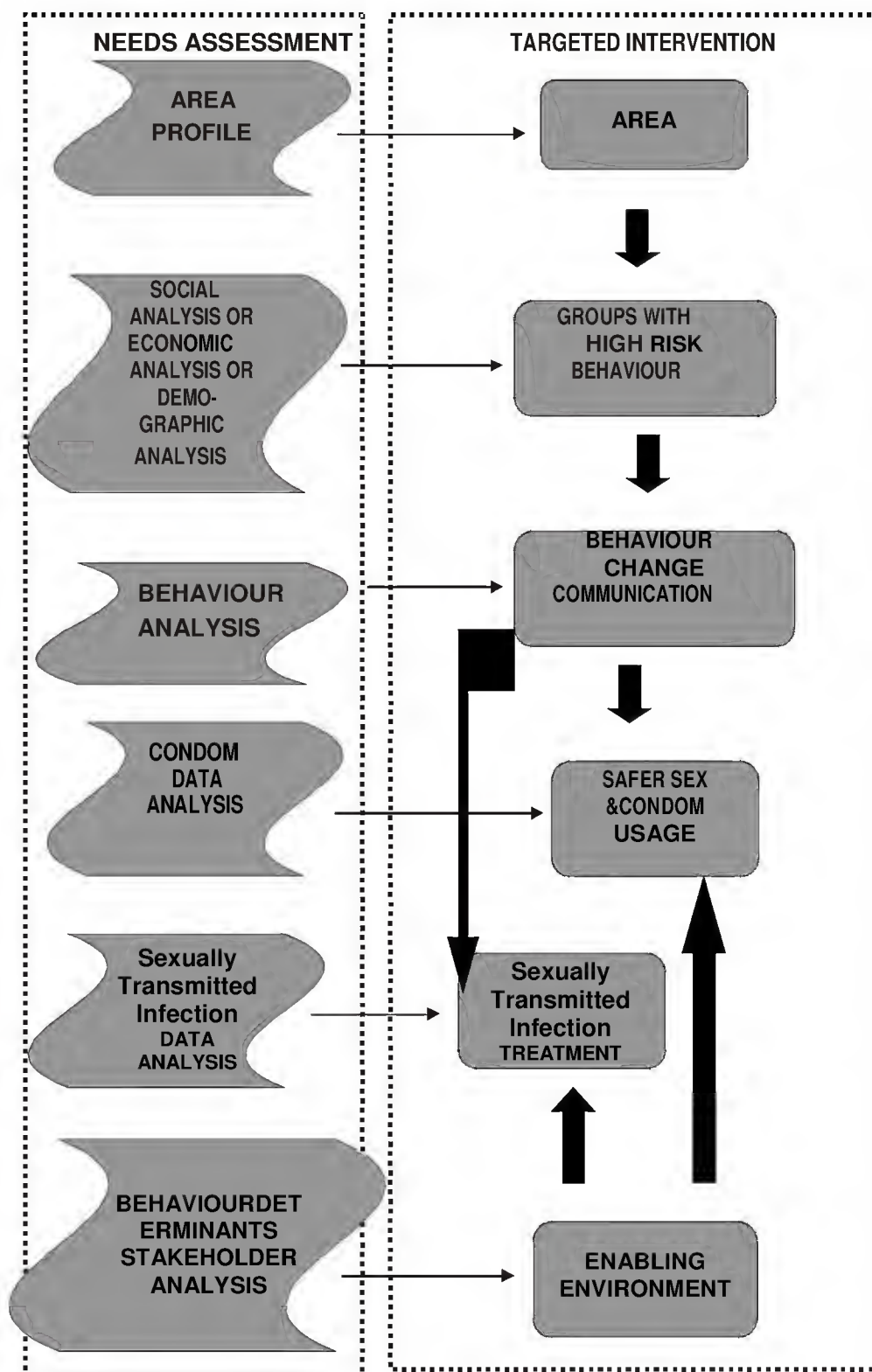


Figure 3.1 Relationship between Needs Assessment or Stakeholder Analysis and Targeted Intervention

## B. Defining stakeholders in migrant interventions

### Primary stakeholders (target population)

- (a) High risk migrant men and women who are interact with or are part of high risk sexual networks (Female Sex Workers, Men Who Have Sex with Men or Transgenders);
- (b) Spouses or sexual partners of migrants;
- (c) Migrants living with and affected by HIV and AIDS.

### Placement agencies, brokers, *dalals*

who “source” migrants and supply them to contractors form one of the main sets of stakeholders for migrant interventions. Stakeholder Analysis should clearly identify, and advocate with, this critical power structure.

### Secondary stakeholders

- (a) Placement agencies, brokers and others;
- (b) Families of high risk migrant men and women;
- (c) Families of migrants living with and affected by HIV and AIDS;
- (d) Sexual network operators (Female Sex Workers, Men Who Have Sex with Men or Transgenders) and power structures;
- (e) Health care providers (government and private, qualified, unqualified);
- (f) Non-Governmental Organisations, Community Based Organisations and other agencies implementing Tis;
- (g) Workers associations, employees unions, trade unions;
- (h) Infected and affected migrants, People Living with AIDS networks.

### Tertiary stakeholders

- (a) Industrial centres, informal workplace institutions, employers associations, other allied organisations and structures;
- (b) Community-level voluntary structures, e.g. migrants and youth forums or clubs, mandals, safe spaces or drop-in centres for migrants (Spaces for Migrants);
- (c) Decision makers in the community, i.e. social and political leaders, police, elected representatives (Panchayati Raj Institutions), development functionaries;
- (d) Non-Governmental Organisations, Community Based Organisations, CSOs;
- (e) State AIDS Control Society in both source and destination states;
- (f) National AIDS Control Organisation and the donor agencies.

## C. Location of stakeholders

A separate needs assessment and Stakeholder Analysis has been envisaged for each type of intervention area (prioritised industrial or workplace locations, large residential locations and hot spots) for undertaking Targeted Interventions with high risk migrants. This exercise will yield relevant stakeholders, and depending upon the role they might play, an appropriate strategy for their involvement may be designed.

### Prioritised industrial or workplace centres

Working with the owners and social welfare officers of industrial or workplace centres is essential to create an enabling environment for successful implementation of the project. Many such industrial or workplace centres engage various contractors for labour and raw material supply, and these also form an important category of stakeholder as they have greater influence on the migrant population. There may be canteens and *dhabas* in and around the workplaces, and their owners can be tapped to reach out to the target population. Similarly, security agencies employed by the workplaces could emerge as another stakeholder.

### Residential areas of migrants

Some areas in the place of destination are obvious and well known living places for migrants, e.g. slums and temporary shelters. A transect walk in these areas and conducting the Needs Assessment Stakeholder Analysis will help to locate influential stakeholders such as *kabadi* shops, tea stalls and cigarette shops that can be involved in reaching out to the target population. Often, unqualified private practitioners whom residents of slums and temporary settlements visit for their day-to-day medical needs will be identified as key stakeholders.

### Hotspots

Sometimes there are known hotspots where migrants congregate (e.g. sex worker hotspots, cinema halls). These can be useful areas to identify possible methods of intervention (e.g. mid-media activities).

### Cross-cutting stakeholders

Apart from separate stakeholders specific to each intervention site, there may be some “cross-cutting” stakeholders whose interests are not bound to a specific location. These include unions to which migrant populations are attached and without whose help and support they often do not get jobs at the place of destination. Examples include *riksha* pullers unions, auto drivers associations and traders associations (particularly in vegetable and grain *mandis*, etc.).

### D. When to do it?

Stakeholder Analysis is a part of the needs assessment exercise. Once the area of intervention has been finalised the needs assessment and Stakeholder Analysis will be conducted in turn. “Social sanction activities” are helpful to establish an initial rapport with the community before Stakeholder Analysis is conducted, for example by organising mid-media activities in the intervention areas.

Stakeholder Analysis involves participatory techniques such as social mapping, focus group discussion, in-depth interviews or Key Informant interviews. **See Annexure 9, Information Collection in Stakeholder Analysis.**

### E. Who will do it?

Outreach Workers and senior staff of the Non-Governmental Organisation along with some key stakeholders carry out the Stakeholder Analysis.

It is important to note that the information or data collected by various needs assessment exercises like focus group discussions, in-depth interviews, Key Informant interviews, transect walks will form the basis of the Stakeholder Analysis.

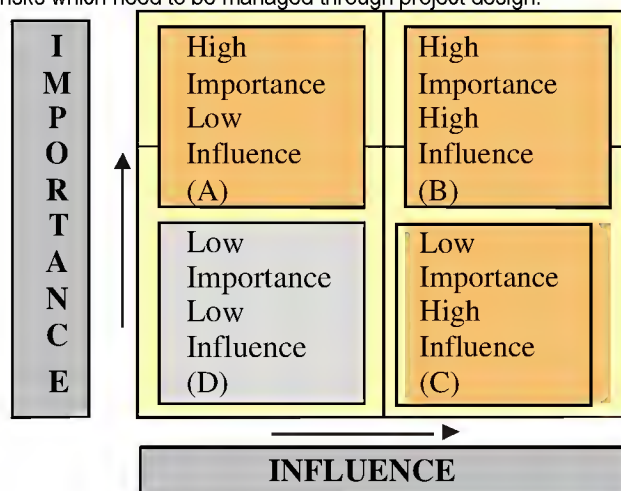
Since it is impossible to gather all stakeholders together, these groups should be met with separately in the initial stage of the project. Through the Stakeholder Analysis, clarity about the various stakeholders’ roles in the project cycle will help to ensure support based on mutually agreed expectations. Conflicting parties must know that the project objectives are the binding force for meeting and interaction among stakeholders. A clear and transparent process will ensure that a heterogeneous group of stakeholders gradually coalesces towards a common goal.

### F. Steps in Stakeholder Analysis

- Draw up a “stakeholders table”;
- Identify stakeholders’ interests in the project and rank them according to their importance to the project’s success;
- Assess stakeholders’ relative influence over the beneficiaries;
- Conduct a comparative analysis between stakeholders’ importance and influence;
- Plan their involvement in project cycle accordingly;
- Share the analysis with key stakeholders.

### Importance vs. influence

Importance is distinct from influence. For example, there will be stakeholders, especially unorganised primary stakeholders, upon whom the project places great importance. However, these stakeholders may have limited capacity to influence key decisions. By considering influence and importance, stakeholders can be classified into different groups, which will help identify the assumptions and risks which need to be managed through project design.



**Box A:** Stakeholders of high importance to the intervention, but with low influence. They require special initiatives if their interests are to be protected.

**Box B:** Stakeholders of high importance to the intervention who can also significantly influence its success. Managers and donors will need to develop good working relationships with these stakeholders to ensure an effective coalition of support for the intervention.

**Box C:** Stakeholders with high influence, who can affect outcome of the intervention, but whose interests are not the target of the intervention. These stakeholders may be able to block the intervention and therefore require careful management.

**Box D:** Stakeholders who are of low priority but may need limited monitoring. They are unlikely to be the focus of the intervention.

Those included in Boxes A, B and C are the key stakeholders in the intervention: they can significantly influence it or are most important to the intervention's objectives.

### Participation matrix

The next step is to plan the extent and nature of the participation of stakeholders in different stages of the intervention (from being informed about the intervention to being an active participant or a partner). A discussion with stakeholders based on the findings of the influence-importance matrix leads to a "participation matrix" to identify appropriate stakeholder participation.

An example of a participation matrix is provided below to illustrate this point. In this matrix, certain stakeholders have been ranked on importance and influence on a scale of 1 to 5, with 1 being the least important or influential and 5 being the most.

Stakeholder No.	Stakeholders [examples]	Ranking according to importance	Influence in the community as well as on the migrants	Category of Participation			
				Inform	Consult	Implement	Partner
1.	Workplace owners	4	5	X	X	X	X
2.	Placement agencies	5	5	X	X	X	X
3.	Private Medical Practitioners	5	4	X	X	X	X
4.	Riksha Puller	5	2	X			
5.	Riksha Garage Owner	3	4	X			
6.	Money Lenders	3	1	X			
7.	Dhaba owner	1	4		X		X

### Tool

#### Annexure 9 Information Collection in Stakeholder Analysis

##### 3.1.2

##### Step 2: Peer Education

**Approach:** The peer education approach for migrants differs in two critical ways from the model for other Targeted Interventions under National AIDS Control Programme III.

- 1. Volunteerism:** Peers are volunteers who engage in the project and are NOT paid honorariums or salaries by the Targeted Intervention, unlike in the case of other Targeted Interventions. Volunteer Peer Leaders are thus the basis of peer education for migrants.
- 2. Mid-media plays the central role in communications, not Interpersonal Communication:** While Targeted Interventions for other High Risk Groups focus on Interpersonal



Communication as the main mode of communication, mid-media is the core method of peer education for migrants (as also with truckers).

Peer education is one of the most widely used strategies to address the HIV or AIDS pandemic. A peer is one of equal standing with another, one belonging to the same societal group especially based on age, grade or status. The purpose of Volunteer Peer Leaders is to ensure that High Risk Groups are reached and information on Sexually Transmitted Infections and HIV or AIDS is shared with them to bring out a positive behaviour change. For Targeted Interventions to migrants, Volunteer Peer Leaders are envisaged as volunteers from the migrant community.

Peer involvement is an effective way of reaching communities and affecting change in community norms. Volunteer Peer Leaders are knowledgeable "insiders" in migrant settings, and their involvement enhances trust and communication. Volunteer Peer Leaders are consequently a credible source of advice. They can be powerful role models and can help to change social norms. Volunteer Peer Leaders also act as a link between migrant workers and Targeted Interventions, facilitating local participation. Peer networking and the sharing of information often leads to community mobilisation around issues of concern.

Objectives of Peer Education	Advantages of Volunteer Peer Leaders
<ul style="list-style-type: none"> <li>(a) To contact and educate or sensitise a maximum number of the target group through Interpersonal Communication</li> <li>(b) To increase the knowledge of the target group on Sexually Transmitted Infections, HIV or AIDS and condom use</li> <li>(c) To motivate the target group to practice safer sex behaviour and access health services through a credible and acceptable channel of communication</li> </ul>	<ul style="list-style-type: none"> <li>(a) Based at the project's working area</li> <li>(b) Have good rapport with the target audience</li> <li>(c) Belong to the same professional segment as the High Risk Group</li> <li>(d) Are easily accessible to the primary stakeholders round the clock</li> <li>(e) Can give sustainability to the project as they will remain in the area even after the project graduates out</li> </ul>

### A. Role of the Volunteer Peer Leader

Volunteer Peer Leaders are a link between project and migrant workers. Their main responsibilities are:

#### (i) Operational elements :

- (a) Undertake risk assessment of migrant population in their area of operation based on criteria of multi-partner sex and history of Sexually Transmitted Infection status, and identify at-risk individuals for the purposes of the Targeted Intervention. This can be done through one-to-one contacts. Volunteer Peer Leaders also need to identify those migrants who overlap with high risk sex networks (either as sex workers or clients of sex workers);
- (b) Link migrant workers with project services such as condoms, counselling and referral services, e.g. testing, care and support, etc;
- (c) Collect data related to the project for planning;
- (d) Support condom promotion activities undertaken by Non-Governmental Organisation staff and or other organisations engaged for mid-media campaign for condom promotion;
- (e) Mobilise the target group to participate in mid-media campaign activities, e.g. street plays, video shows, slide shows, infotainment, health camps, mobile exhibition, World AIDS Day programmes, etc. conducted by Non-Governmental Organisation staff;

#### (ii) Behaviour Change Communication :

- (a) Sharing information related to HIV or AIDS and safer sex practices with those migrants who are at risk of HIV;
- (b) Use of Behaviour Change Communication materials for effective Interpersonal Communication to address myths and misconception regarding HIV or AIDS;
- (c) Motivate and dialogue with migrants who are at risk to adopt safer sexual practices;
- (d) Education on condom usage: buying, storing, opening, using, and disposing;

- (e) Encourage migrants to maintain cleanliness and personal hygiene.
- (iii) Sexually Transmitted Infections:
  - (a) Create awareness among the migrant population of common symptoms of Sexually Transmitted Infections and the need to seek appropriate treatment from qualified practitioners;
  - (b) Support migrant workers in accessing Sexually Transmitted Infection treatment services (project-run or referral services);
  - (c) Remove myths and misconceptions related to Sexually Transmitted Infection;
  - (d) Follow up Sexually Transmitted Infection patients and their partners wherever possible for treatment compliance;
  - (e) Mobilise migrants for health camps and related events in the areas;
  - (f) Provide referral slips or cards.
- (iv) Care and support:
  - (a) Identify and support People Living with AIDS in the migrant workers area;
  - (b) Help them to access treatment;
  - (c) Link to other departments to provide psycho-social support.
- (v) Advocacy:
  - (a) Meet with community leaders identified through the Stakeholder Analysis and stakeholders for sensitisation on HIV or AIDS and project activities;
  - (b) Facilitate community resources for the project.
- (vi) Linkages with HIV and other services:
  - (a) Linkages with Antiretroviral Therapy centre;
  - (b) Identification of early symptoms of Tuberculosis and referral to Directly Observed Treatment Short-Course Chemotherapy;
  - (c) Help them to access testing and Integrated Counselling and Testing Centres.

## B. Selection criteria for Volunteer Peer Leaders

Following are key considerations for PE selection:

- (a) Must be of the same ethnic group as the migrant population;
- (b) Willing to work for the community on a volunteer basis;
- (c) Demonstrate self-confidence and show potential for leadership;
- (d) Good listening, communication, and interpersonal skills;
- (e) Understanding of the cause and committed to the goals of the project;
- (f) Knowledge of problems and difficulties of the community;
- (g) Should be acceptable among the target audience with whom they will work.

## C. Identifying potential of Volunteer Peer Leaders

Based on some of the considerations above, the identification of context-specific Volunteer Peer Leaders for migrant Targeted Interventions may proceed using the following list of examples:

- (a) Petty shop owners in and around the area where migrants work, congregate or reside, e.g. mechanic shop owner, owners of small hotels which provide lunch and dinner for the target population, owners of popular tea shops, *paan* and cigarette shopkeepers, etc.;
- (b) Members of various associations of migrant workers, e.g. riksha puller association, auto drivers association, supervisors of those working as labourers at various mandis;
- (c) Contractors who supply labourers for skilled or unskilled work, including construction;
- (d) Social welfare officers of workplaces which employ migrant workers on a casual basis;

The identification of Volunteer Peer Leaders should be initiated as part of project activities such as the Needs Assessment and Stakeholder Analysis and determining individual migrants who are at most risk.

#### **D. Capacity building strategy for Volunteer Peer Leaders**

Working as a PE requires special skills, and it is important to build capacity on technical as well as operational aspects of the project activities.

##### **Capacity Building Structure**

- (a) Initial structured sessions
- (b) Periodic refresher sessions
- (c) Supervision
- (d) Ongoing interaction and support for problem-solving

A cascade training approach is envisaged for building capacity of Volunteer Peer Leaders. A cadre of "Master Trainers" will be developed by State AIDS Control Society for overall support of migrant Targeted Interventions in the State and Districts. The main responsibility of these Master Trainers is to train the Non-Governmental Organisation staff on:

- (a) The basics of HIV or AIDS
- (b) Conducting needs assessment and Stakeholder Analysis
- (c) Project operational plans
- (d) Approaches and methods of selection of Volunteer Peer Leaders
- (e) Organising capacity building sessions for Volunteer Peer Leaders

The trained staff of the Non-Governmental Organisation, supported by the Master Trainers, will conduct a two-day structured training programme for the Volunteer Peer Leaders. Once the Volunteer Peer Leaders are trained on technical and operational aspects of the project elements, Non-Governmental Organisation staff will be in touch with them during regular field visits. A monthly capacity building cum review meeting can be organised with Volunteer Peer Leaders by the Non-Governmental Organisation staff to help solve any operational problems, discuss field activities and provide necessary support.

To maintain the motivation level of the Volunteer Peer Leaders, the Non-Governmental Organisation should organise quarterly one-day structured refresher programmes. The operational support and handholding of Volunteer Peer Leaders will help sustain their motivational level, facilitate field-level problem solving and encourage their participation in project activities.

The capacity building strategy should follow the following framework:

Training Components	Methodology	Duration	Potential Resources
<ul style="list-style-type: none"> <li>(1) HIV or AIDS and Sexually Transmitted Infections</li> <li>(2) Sex and sexuality</li> <li>(3) Drug abuse</li> <li>(4) Alcoholism</li> <li>(5) Community counselling</li> <li>(6) Health service linkages</li> <li>(7) Condom promotion</li> <li>(8) Reproductive health</li> <li>(9) Gender</li> <li>(10) Skills building on mobilisation, advocacy and communications</li> </ul>	<ul style="list-style-type: none"> <li>(1) Lectures</li> <li>(2) Games</li> <li>(3) Screening of video films</li> <li>(4) Quizzes</li> <li>(5) Sharing of experiences by a PE who has worked in HIV or AIDS outreach</li> </ul>	<ul style="list-style-type: none"> <li>(1) Two days for initial training</li> <li>(2) One-day refreshers every quarter</li> </ul>	<ul style="list-style-type: none"> <li>(1) Master trainers</li> <li>(2) Non-Governmental Organisation staff</li> <li>(3) Experienced PE</li> </ul>

Volunteer Peer Leaders may initially face hostility from the community they seek to serve. Working in groups provides support and strength in numbers. In order to be effective, Volunteer Peer Leaders need to be seen and heard regularly.

#### **Materials required by Volunteer Peer Leaders**

- (a) Flip book
- (b) Hand bills
- (c) Penis model

- (d) Condoms
- (e) Sexually Transmitted Infection Flip book
- (f) Referral Cards
- (g) Daily Diary
- (h) Bag or Cap or Badges

### E. Sustainability of the peer education programme

Intentional strategies must be followed to make the peer education programme viable throughout the time of the Targeted Intervention and beyond. These include:

- (a) Develop a cadre of motivated Volunteer Peer Leaders and encourage them throughout the project period;
- (b) Initiate federation or networking or group formation of Volunteer Peer Leaders at local level at the later stages of the project implementation. After establishing the Targeted Intervention and "handholding" for some time, an attempt should be made to form a Community Based Organisation of Volunteer Peer Leaders, in order to sustain project activities into the future. Other approaches to organising Volunteer Peer Leaders in formal or informal groups may be attempted depending upon the context and with active participation from the Volunteer Peer Leaders;
- (c) Institutionalise recognition systems and establish mechanism for regular interactions among Volunteer Peer Leaders as well as between Volunteer Peer Leaders and key stakeholders, including government counterparts.

### F. Recognition for Volunteer Peer Leaders

Volunteer Peer Leaders are expected to work with the project on a voluntary basis, and to continue as a volunteer with the same activities beyond the project life span. To maintain their motivation to carry out stipulated tasks on a voluntary basis even with the project's time frame, a recognition and reward system should be devised by the project. While this system may vary in different contexts, it is essential in order to keep Volunteer Peer Leaders engaged in project activities. The recognition and reward system should accomplish two objectives:

- (a) Reward superior performers and recognise outstanding accomplishments based on specific, measurable and transparent criteria
- (b) Make the status of a peer with the programme aspirational for the target group

Examples of recognition and reward activities include:

- (a) Monthly meetings for Volunteer Peer Leaders to learn from one another;
- (b) Follow-up refresher training;
- (c) Maintaining continued periodic interactions in the field;
- (d) Providing extra or enhanced materials to facilitate Volunteer Peer Leaders' work, e.g. diary, reference materials, flip books, posters, handbills, stickers, etc.;
- (e) Exposure visits to various similar Tis;
- (f) Developing a healthy competitive attitude among Volunteer Peer Leaders;
- (g) "Peer of the Month" award;
- (h) Certificates or badges for good performance;
- (i) Gifts and recognition awarded by celebrities.

### 3.1.3 Step 3: Behaviour Change Communication

The aim of Behaviour Change Communication is to make individuals perceive, understand and accept their self-risk due to specific behaviours and to create a desire for preventive action.

A Behaviour Change Communication plan for migrants should be based on the following considerations:

- (a) What are the barriers to adoption of safe behaviours or factors that encourage adoption of unsafe behaviours?
- (b) What are the factors that can be used to motivate change in behaviour?
- (c) What are the most appropriate timings and venues for Behaviour Change Communication (mid-media and Interpersonal Communication)?
- (d) What types of Information, Education and Communication and Behaviour Change Communication material are most appropriate as communication tool?



(e) What is the mix of languages within the community?

Behaviour Change Communication for migrant Targeted Interventions has two primary components: mid-media and Interpersonal Communication.

**A. Mid-media**

Mid-media is a creative and efficient way of generating awareness on certain key issues among large numbers of people. Interactive mid-media techniques, such as street theatre in which the audience is invited to comment on a dramatic situation, can be used to provoke a discussion on community norms. Examples of mid-media include:

- (a) Street theatre
- (b) Games
- (c) Traditional local media (interactive street theatre, e.g. Bhavai, Ramlila, etc.)
- (d) Exhibitions
- (e) Information, Education and Communication campaigns
- (f) Debates and discussions
- (g) Audio or video or film shows
- (h) Special observances and commemorations (e.g. World AIDS Day)
- (i) Information kiosks (displays of poster and relevant materials with provision of one-to-one counselling)

A professional agency may be engaged to conduct many of the mid-media events (e.g. street theatre performances), but some activities can be conducted by Non-Governmental Organisation staff on a regular basis (e.g. film shows, information kiosks).

**B. Interpersonal Communication**

Mid-media can be supplemented by one-to-one Interpersonal Communication focused on those individuals who are in need of greater information. One-to-one Interpersonal Communication can be delivered immediately after thought-provoking mid-media to that sub-set of the audience that stays back to obtain more information or seek services. In the interest of maximising efficiency, it is important to identify that sub-group of migrants with high risk behaviour (primarily single migrant workers) who need to be provided additional information through one-to-one interaction. One-to-one interaction can focus on:

- (a) Information on HIV or AIDS, means of transmission, prevention, Sexually Transmitted Infections, etc.
- (b) Risk perception of individual
- (c) Understanding of high risk behaviour and its consequences
- (d) Options for safe behaviours
- (e) Information on access to condoms and services available in the area for Sexually Transmitted Infection treatment, HIV testing and counselling

**Contact strategy for Interpersonal Communication**

The ratio of Volunteer Peer Leaders to migrants is 1:100. Within this population of migrants, the PE should identify high risk individuals with the help of Outreach Workers from the Non-Governmental Organisation. High risk migrants should be met with once a week in the initial stages of the project, though the frequency may be modified depending upon the behaviour of the individual migrants (see Annexure 1).

The Non-Governmental Organisation should prepare a detailed Behaviour Change Communication strategy with a conversation plan for Volunteer Peer Leaders identifying a series of topics for discussion, e.g. safe sex methods, correct method of condom use, myths around condom use, partner notification for Sexually Transmitted Infections, etc. It is important to note that while a minimum package should be designed to ensure a basic level of information and services for entire community, peer communication in the field should not be limited to these topics. Peers should be skilled enough to draw on their knowledge and tailor a discussion to the needs and concerns of specific individuals.

**Development of Behaviour Change Communication and Information, Education and Communication materials**

Information, Education and Communication and Behaviour Change Communication material should be developed based on the needs of the community. Existing job aids or migrant-specific Behaviour Change Communication materials in the form of flipcharts, case studies and story-based flashcards can be adapted for use by Volunteer Peer Leaders. It is important to use images and situations with which the migrant population can identify. Often there will be a need for material in more than



one language within one project. The language mix should be based on the profile of the migrant community (as indicated by the initial mapping and Needs Assessment Stakeholder Analysis exercises).

The Behaviour Change Communication material should be developed and adapted in a participatory way by conducting pre-testing protocols after considering regional, cultural and target group characteristics.

### 3.1.4 Step 4: Sexually Transmitted Infection Management

Targeted Interventions for migrants will focus on four aspects of Sexually Transmitted Infection prevention and management:

- (a) Activities to generate awareness of Sexually Transmitted Infection symptoms while emphasising the long-term consequences of such infections, the need for correct and complete treatment, and the means of prevention
- (b) Establishment of a referral network for treatment by interacting with existing health care providers, both public as well as private health facilities as mapped in and around the project site, including training on syndromic case management for providers
- (c) Follow-up and tracking to improve treatment-seeking and compliance with treatment. Volunteer Peer Leaders and Outreach Workers may use referral slips to monitor whether clients have followed up on referrals (**see Annexure10, Referral Slip**).
- (d) Ensuring condom availability

The Sexually Transmitted Infection services to be provided are:

- (a) Health promotion and Sexually Transmitted Infection prevention activities, such as promoting correct and consistent use of condoms
- (b) Provision of condoms
- (c) Immediate diagnosis and clinical management of Sexually Transmitted Infections using syndromic case management
- (d) Health education and counselling for treatment compliance, correct and consistent use of condoms and regular partner treatment
- (e) Partner management programmes (i.e. contact referral)
- (f) Follow-up services
- (g) Counselling for HIV positive persons
- (h) Referral links to Integrated Counselling and Testing Centre, HIV care and support and other relevant services.

**As per the National AIDS Control Organisation Sexually Transmitted Infection drug procurement guidelines, all Sexually Transmitted Infection drugs are to be procured by State AIDS Control Society or National AIDS Control Organisation. No drugs for Sexually Transmitted Infections are to be purchased by Non-Governmental Organisations.**

### A. Planning for Sexually Transmitted Infection services

The needs assessment undertaken at the start of the project should generate data on the following:

- (a) Information on current barriers to accessing Sexually Transmitted Infection services
- (b) Ways in which Sexually Transmitted Infection services can be made accessible and acceptable to the community in terms of location, operating hours, etc.
- (c) Context-specific preferred list of physicians

Once this information has been gathered, the Non-Governmental Organisation must network with the identified service delivery providers to establish dependable services and to orient staff on syndromic case management and treatment of Sexually Transmitted Infections.

	Referral to Public Sector	Referral to Qualified Private Sector
<b>Advantages</b>	(1) Free services	(1) Ensures confidentiality (2) Sustainable services
<b>Disadvantages</b>	(1) May lack confidentiality (2) Unpredictable quality	(1) Cost

	(3) Possible stigmatisation of Sexually Transmitted Infection patients by staff	
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In addition to these technical or medical considerations, special attention should be paid to ensuring that Sexually Transmitted Infection service delivery options are community-friendly. This means:

- (a) Clinicians with a supportive attitude towards the community
- (b) Availability of services as per the needs of the community, e.g. late-night access
- (c) Access to services at optimal location (e.g. not too far from major sex work sites, not requiring outlay for public transport)
- (d) Basic infrastructure of facility as per National AIDS Control Organisation Sexually Transmitted Infection guidelines
- (e) Confidentiality between the clinic team and the community

### B. Referral services for other illnesses

The project should actively create referral linkages for other health concerns of migrants. Again, such linkages can draw on both government facilities as well as qualified private practitioners.

### C. Social marketing of Sexually Transmitted Infection services

Health services and drugs for migrants should be socially marketed, as opposed to free of cost, for the following reasons:

- (a) Migrants have disposable income and therefore can afford to pay socially marketed rates for such services
- (b) Such services are valued more by the community when they are provided at a nominal fee
- (c) Services are perceived to be of higher quality when provided at a nominal charge
- (d) This is more sustainable than providing services free of cost. Private practitioners can more easily be engaged by the programme on a social marketing model

#### Tool

#### Annexure 10 *Referral Slip*

#### 3.1.5 Step 5: Condom Programming

Condom promotion in migrant Targeted Interventions entails:

1. Regular demand-generation activities to increase visibility, perception of accessibility and demand for condoms
2. Ensuring availability of an adequate supply of socially marketed condoms at traditional and non- traditional condom outlets in and around the project sites
3. Condom demonstrations by Volunteer Peer Leaders and Outreach Workers to ensure correct usage of condoms.

A Social Marketing Organisation should be contracted for activities (1) and (2) above. The project should undertake training and capacity-building of Volunteer Peer Leaders and Outreach Workers to build their knowledge of the benefits of condom use and to impart skills in conducting condom demonstrations and addressing common misconceptions surrounding condoms (reduced pleasure, breakage, etc.).

#### A. Monitoring condom availability

Volunteer Peer Leaders and Outreach Workers should also be encouraged to solicit feedback on the availability of condoms, preferred brands, etc. This information should be provided to the Social Marketing Organisation to improve distribution. Condom availability at the intervention location should be assessed according to the following:

- (a) **Number of outlets carrying condoms:** Focus should be on those outlets that are convenient for migrants, e.g. those open at night. It is necessary to monitor distribution in traditional and non- traditional outlets. Non-traditional outlets are those that are not retail outlets (e.g., bars, *dhabas*, barbers, etc.). Such outlets are often more convenient and accessible for migrants.

- (b) Visibility of condoms at these outlets:** Merchandising at outlets (i.e. prominent display of condoms, posters, banners, etc.) helps increase demand for condoms. Often merchandising material triggers recall of a message and prompts a purchase.

### B. Condom boxes

In corporate-sponsored workplace interventions, condom boxes may be provided at the site. Condom boxes enable workers to access condoms anonymously and free of cost. They should be installed at accessible and relatively private locations (e.g. toilets). Volunteer Peer Leaders can be charged with ensuring that adequate supplies are available through condom boxes.

#### 3.1.6 Step 6: Community Mobilisation – Safe Spaces for Migrants

Community mobilisation entails creating a platform for the community to come together to discuss common issues and social norms and to build a collective desire for preventive action. In order to create such a platform, the project should create “safe spaces” for migrants:

- (a) The concept of “Space for Migrants” takes into account the multiple needs of migrants, with a focus on building their social capital to reduce their vulnerability to HIV or AIDS
- (b) State AIDS Control Society will contract Non-Governmental Organisations or migrant support organisations to establish Spaces for Migrants in partnership with the Urban Development Agency who work in slums and or private sector organisations (if possible)
- (c) Space for migrants (like Drop-In Centres for High Risk Groups) should be located by Non-Governmental Organisations through the following process:
  - (i) Identify existing congregation points for migrant workers. These may include places of entertainment like video parlours, bars, etc. In the case of a workplace intervention, a congregation point may be a common resting area or lunch room.
  - (ii) If an existing congregation point is not found to be appropriate, the project should create a new facility that can be used as a project centre
- (d) Spaces for Migrants are managed by Volunteer Peer Leaders and provide the following services:
  - (i) Volunteer Peer Leaders to provide minimum information on HIV or AIDS and related subjects to migrant workers. Information could include awareness on HIV or AIDS prevention and care, combined in a creative way with information beyond HIV which addresses migrant needs (e.g. how to remit money home, banking options, social welfare services).
  - (ii) Information, Education and Communication material available for easy access by migrant workers
  - (iii) Socially marketed condoms
  - (iv) Referral to Integrated Counselling and Testing Centres and Sexually Transmitted Infection clinics
  - (v) Recreational material including radio, TV, games, magazines or newspapers, etc.
  - (vi) Activities aimed at reducing drug and alcohol related vulnerabilities
  - (vii) Outreach facilities including periodic health camps

#### 3.1.7 Step 7: Creating an Enabling Environment

The process of the Stakeholder Analysis is an important component of creating an enabling environment for the Targeted Intervention. The Targeted Intervention should also have linkages with government departments in order to meet non-HIV needs of the target population. To be effective, it is essential that the Targeted Intervention create an environment where as many needs of the migrant population as possible are met relating to their living conditions, human and workers rights, etc. Key government departments with whom enabling environment efforts in migrant Targeted Interventions should focus include:

- (a) **Health Department:** To access other health services under urban and rural health programmes;
- (b) **Labour Department:** For unionising and implementation of labour laws;
- (c) **Civil Services Department:** For basic amenities related to water, electricity, drainage, etc. at the place of stay;

(d) **Transportation Department:** To develop support services for migrant populations and link them with their families in their source states;

(e) **Industry Department:** To advocate for compliance with codes of conduct for HIV or AIDS.

## 3.2 PROGRAMME MANAGEMENT

### 3.2.1 Service Package

Location	Package of services	Agency responsible for service delivery
Hotspots	(1) Condom promotion and distribution (2) Large-group format activities (e.g. street theatre, games, etc.) (3) Referrals to qualified medical practitioners for treatment of Sexually Transmitted Infections	(1) Social Marketing Organisations (2) Non-Governmental Organisation partner (for setting up referral linkages and overall monitoring)
Industry or workplace centres	(1) Condom promotion and distribution (2) Large-group format activities (e.g. street theatre, games, etc.) (3) Focused Interpersonal Communication (through peers and Non-Governmental Organisation workers) (4) Referrals to qualified medical practitioners for treatment of Sexually Transmitted Infections (5) Development of point of congregation as project centre with availability of Information, Education and Communication material and socially marketed condoms (6) Recruitment of volunteers, advocacy (7) Workplace policy guidelines (8) Linkages with other programmes and entitlements	(1) Informal workplace (2) Formal workplace (e.g. industrial house, corporate houses) (3) Corporate- backed Non-Governmental Organisations
Residential clusters	(1) Condom promotion and distribution (2) Large-group format activities (e.g. street theatre, games, etc.) (3) Focused Interpersonal Communication (through peers and Non-Governmental Organisation workers) (4) Referrals to qualified medical practitioners for treatment of Sexually Transmitted Infections (5) Development of point of congregation as project centre with availability of Information, Education and Communication material and socially marketed condoms (6) Recruitment of volunteers, advocacy (7) Linkages with other programmes	(1) Non-Governmental Organisation (2) Social Marketing Organisations (for Condom Social Marketing and promotion)

### 3.2.2 Operational Strategy and Implementation Plan

The following table lists the suggested activities for establishing an effective Targeted Intervention for migrants and identifies those who are responsible for conducting each activity, as well as the timeline. Such detailed activity planning could be prepared separately for each type of intervention site (hot spots, prioritised industry or workplace locations and residential locations). Separate implementation plans will indicate specific activities and relevant stakeholders.

[illegible]



Activities	Responsibility	Timeline											
		Year 1				Year 2				Year 3			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Monitor availability of condoms or strengthen social marketing efforts of Social Marketing Organisation	Non-Governmental Organisation supervisory level staff or outreach staff		x	x									
Network with Social Marketing Organisation for SM product placement	Non-Governmental Organisation management		x	x									
One-to-one contact with migrants for disseminating information, condom demonstration	Volunteer Peer Leaders or Non-Governmental Organisation outreach workers		x	x	x	x	x	x	x	x	x	x	x
Conduct mid- media activities at intervention sites	Non-Governmental Organisation staff or Volunteer Peer Leaders or Social Marketing Organisations		x	x	x	x	x	x	x	x	x		
Conduct one-to-group meetings with migrant population	Volunteer Peer Leaders or Non-Governmental Organisation outreach staff		x	x	x	x	x	x	x	x	x	x	
Identify qualified service providers for Sexually Transmitted Infection treatment	Non-Governmental Organisation staff	x	x										
Network with government health services for Sexually Transmitted Infection treatment	Non-Governmental Organisation staff	x	x										
Identify, refer and follow up on Sexually Transmitted Infection cases	Volunteer Peer Leaders or outreach workers		x	x	x	x	x	x	x	x	x	x	x
Stakeholder meeting and their involvement in the project	Non-Governmental Organisation staff		x	x	x	x	x	x	x	x	x	x	
Conduct final evaluation survey (Behaviour Surveillance Survey)	External agency												x

### 3.2.3 Monitoring and Evaluation

Monitoring and Evaluation of Targeted Interventions for migrants is an essential and integral part of the overall project design. This section presents the overall framework for Monitoring and Evaluation, including specific indicators for monitoring the project activities and those which need to be collected as part of project evaluation.

#### A. Monitoring indicators:

The principle applied here is to collect monitoring data which is most relevant for taking decisions at the field level; the information generated from the monitoring system is used to provide feedback to the project activities on a regular basis to take any needed corrective actions. Various indicators along with numerator and denominators for computing indicators and sources of information are outlined in the following table:

SI	Indicators	Calculation	Frequency	Data Source
1	Total number of migrant population who are identified as high risk	Numerator: Number of migrant population found to practice high risk behaviours		Based on second layer of Mapping methodology by Non-Governmental Organisation staff
2	% of sites having trained Volunteer Peer Leaders as per the recommended ratio for (PE: Migrant population)	Numerator: Number of sites having trained Volunteer Peer Leaders as per the recommended ratio Denominator: Total number of intervention sites	Monthly	Non-Governmental Organisation Monthly Project Register
3	% of identified Volunteer Peer Leaders trained	Numerator: Number of trained Volunteer Peer Leaders Denominator: Total number of identified Volunteer Peer Leaders	Monthly	Non-Governmental Organisation Monthly Project Register
4	% of trained Volunteer Peer Leaders that demonstrate	Numerator: Number of trained Volunteer Peer Leaders that demonstrated adequate knowledge	Quarterly	See Annexure 11, Ongoing Assessment of Volunteer Peer Leaders and Migrants

SI	Indicators	Calculation	Frequency	Data Source
	adequate knowledge of Sexually Transmitted Infection or HIV transmission and prevention	Denominator: Total number of Volunteer Peer Leaders included in the assessment		(conducted by supervisory and higher level Non-Governmental Organisation staff)
5	% of trained Volunteer Peer Leaders that demonstrate adequate condom demonstration skills	Numerator: Number of trained Volunteer Peer Leaders that demonstrated adequate condom demonstration skill Denominator: Total number of Volunteer Peer Leaders included in the assessment	Quarterly	See Annexure 11, Ongoing Assessment of Volunteer Peer Leaders and Migrants (conducted by supervisory and higher level Non-Governmental Organisation staff)
6	Average number of one-to-one contacts organised by Volunteer Peer Leaders during past month	Numerator: Sum of all one-to-one contacts made by the Volunteer Peer Leaders Denominator: Total number of Volunteer Peer Leaders	Monthly	Outreach Worker or Non-Governmental Organisation Monthly Project Register
7	% of Volunteer Peer Leaders conducting one-to-one contacts in the intervention area	Numerator: Number of Volunteer Peer Leaders conducting one-to-one contacts Denominator: Total number of Volunteer Peer Leaders	Monthly	Non-Governmental Organisation Monthly Project Register
8	Average number of one-to-group contacts organised by Volunteer Peer Leaders during past month	Numerator: Sum of all one-to-group contacts made by the Volunteer Peer Leaders Denominator: Total number of Volunteer Peer Leaders	Monthly	Outreach Worker or Non-Governmental Organisation Monthly Project Register
9	% of Volunteer Peer Leaders conducting one-to-group contact in the intervention area	Numerator: Number of Volunteer Peer Leaders conducting one-to-group contact Denominator: Total number of Volunteer Peer Leaders	Monthly	Non-Governmental Organisation Monthly Project Register
10	% of Behaviour Change Communication events by type (Folk media, AV shows and Infotainment) organised against planned	Numerator: Number of Behaviour Change Communication events organised last month by type Denominator: Total number of Behaviour Change Communication events planned for the month	Monthly	Non-Governmental Organisation Monthly Project Register
11	% of persons trained for Targeted Intervention against those planned to be trained (i) Non-Governmental Organisation staff (ii) Qualified health service providers (a) Public (b) Private (iii) Registered Medical Practitioners	Numerator: Number of persons trained by category of participants Denominator: Total number of persons planned to be trained for Targeted Intervention by category	Monthly	Non-Governmental Organisation Monthly Project Register
12	% of migrants referred for Sexually Transmitted Infection or Reproductive Tract Infections who sought treatment	Numerator: Number of migrants who sought treatment from referral service providers for Sexually Transmitted Infection or Reproductive Tract Infections Denominator: Total number of migrants referred to service providers for treatment for Sexually Transmitted Infection or Reproductive Tract Infections	Monthly	Referral slip, Non-Governmental Organisation Monthly Project Register
13	% of functional service providers in the month (i) Public (ii) Private	Numerator: Number of functional service providers in the month Denominator: Total number of service providers identified and included in the referral network for treatment for	Monthly	Referral slip, Non-Governmental Organisation Monthly Project Register

SI	Indicators	Calculation	Frequency	Data Source
		Sexually Transmitted Infection or Reproductive Tract Infections		
14	% of active condom outlets by type (conventional and non-conventional) and by primary target group	Numerator: Number of condom outlets having uninterrupted supply of free and SM condoms during the month Denominator: Total number of condom outlets	Monthly	Non-Governmental Organisation Monthly Project Register
	% of migrants who can state or demonstrate correct use of condoms	Numerator: Number of migrants who could state or demonstrate the correct use of condom Denominator: Total number of migrants included in the assessment	Quarterly	See Annexure 11, Ongoing Assessment of Volunteer Peer Leaders and Migrants
	% of stakeholder meetings organised in the month by type (police, elected representatives, unions and associations, others)	Numerator: Number of meetings organised by type and by primary target group Denominator: Total number of meetings planned	Monthly	Non-Governmental Organisation Monthly Project Register

### B. Evaluation indicators

While the monitoring indicators described above will provide information about project status on a regular basis, evaluation of the Targeted Intervention is to be conducted at the end of the project period to determine the success of the Targeted Intervention in reducing migrants' vulnerability to acquiring HIV or AIDS.

Evaluation indicators are measurable parameters for each component and subcomponent of the Targeted Intervention with a verifiable source of information. The following table describes some of the relevant indicators for project evaluation purposes:

Indicator	Baseline	Target	Means of Verification
<b>KNOWLEDGE</b>			
% knew that consistent condom use reduces the risk of HIV infection (among those who heard about HIV or AIDS)			Behaviour Surveillance Survey
% correctly aware (with no incorrect knowledge) of all 5 ways of HIV transmission (among those who heard about HIV or AIDS)			Behaviour Surveillance Survey
% rejecting at least two misconceptions about reducing (among those who heard about the risk of HIV infection HIV or AIDS)			Behaviour Surveillance Survey
<b>BEHAVIOUR</b>			
% had sex with Commercial Sex Worker or en-route Commercial Sex Worker or non-regular non-commercial partner in last 12 months			Behaviour Surveillance Survey
<b>Condom use in last sex</b>			Behaviour Surveillance Survey
1. With any type of partner			
2. With regular commercial partner			
3. With non-regular commercial partner			
4. With regular non-commercial partner			
5. With non-regular non-commercial partner			
6. With non-marital non-cohabiting partner			
<b>SELF-REPORTING OF SEXUALLY TRANSMITTED DISEASES SYMPTOMS</b>			
% suffer from -			Behaviour Surveillance Survey

Indicator	Baseline	Target	Means of Verification
- Genital Discharge			Behaviour Surveillance Survey
- Genital ulcers or sores			Behaviour Surveillance Survey
% had sex with any partner while suffering from Sexually Transmitted Infections			Behaviour Surveillance Survey
<b>RISK PERCEPTION</b>			
Perception of risk for contracting Sexually Transmitted Infections			Behaviour Surveillance Survey
Perception of risk for contracting HIV or AIDS			Behaviour Surveillance Survey
<b>OTHER</b>			
Time of condom use (before first penetration)			Behaviour Surveillance Survey
Male to male sexual behaviour			Behaviour Surveillance Survey
Median age at sexual debut			Behaviour Surveillance Survey
<b>PROCESS INDICATORS</b>			
% heard about Sexually Transmitted Infections			Behaviour Surveillance Survey
% seeking treatment for Sexually Transmitted Infections (among those who reported having either genital discharge or genital ulcers)			Behaviour Surveillance Survey
% obtained medicines for Sexually Transmitted Infection (among those who sought treatment)			Behaviour Surveillance Survey
% reported completely cured (among those who received medicines)			Behaviour Surveillance Survey
% knew any persons from neighbourhood talking about unprotected sex and danger of Sexually Transmitted Infection or HIV or AIDS			Behaviour Surveillance Survey
% witnessed any Behaviour Change Communication event on HIV or AIDS			Behaviour Surveillance Survey

**Tool****Annexure 11 Ongoing Assessment of Volunteer Peer Leaders and Migrants**

# ANNEXURE 1

## Risk Assessment

### Objectives

A risk assessment seeks to ascertain whether male migrants in the potential intervention area are at risk by gathering the following information:

- (i) Demographic profile of the risk population;
- (ii) Different types of partners among the risk population;
- (iii) Proportion who have correct knowledge about the modes of HIV transmission;
- (iv) Proportion who do not have any myths about the modes of HIV transmission;
- (v) Condom related indicators;
- (vi) Proportion who suffered from Sexually Transmitted Infections in last 12 months;
- (vii) Proportion who sought treatment from a qualified practitioner for Sexually Transmitted Infections;
- (viii) Proportion who feel high risk with a female partner if they have sex in exchange for money or in kind;
- (ix) Proportion who feel it is important to know HIV status;
- (x) Proportion who intend to get themselves tested.

### Study Design:

#### Nature of the study:

Quantitative - data collected through personal interviews with the help of a structured questionnaire

#### Target group

- (i) Male
- (ii) SEC C, D, E1
- (iii) Aged 15 to 44 years

#### Sampling procedure:

- (i) Electoral rolls can be used as sampling frame;
- (ii) Up to 100 polling booths selected through systematic random sampling procedure;
- (iii) In each polling booth area, 2 households identified through systematic random sampling procedure;
- (iv) In each household, 4 interviews conducted following the right-hand rule.

#### Weighting procedure:

- (a) Weighting is necessary to ensure that data correctly represents the overall situation in the intervention area;
- (b) The weighting procedure adopted is detailed below:
  - (i) List total number of males in the household. Weight all males aged 18+ to the male voter population;
  - (ii) From this is derived the total population of those aged between 18-44 years;
  - (iii) Assuming that those aged 15 to 17 years are similar in number to those aged 18-20, the universe of those aged 15-44 can be derived;



- (iv) For each male there is data at household level (bachelor or family households and SEC) and at individual level (age, education and marital status). Of these data, the most critical type is household and age;
- (v) Hence for each of the cells of age X type of household the universal figures can be derived;
- (vi) These weights are then applied to the individual section of responses.

### Definition of Those at Risk:

In last 12 months fell into any one of the categories below one or more times:

- (a) Had sexual intercourse;
  - (i) With female partner in exchange for money;
  - (ii) With female partner in exchange for kind.
- (b) Had sexual intercourse with male partner in exchange for money;
- (c) Had sexual intercourse with eunuch in exchange for money.

No.	Questions	Coding Categories		
1	Age	Age _____		
2	Ethnicity	Ethnicity _____		
3	Marital status	Never married		01
		Married, staying with wife		02
		Married, not staying with wife		03
		Other _____		04
4	Household type	Family		01
		Bachelor		02
5	Occupation	Unskilled		01
		Skilled		02
		Petty Trader		03
		Other		04
6	SEC			
7	(i) Sexual partners (excluding wife) in the last 12 months:			
	(ii) Female for money	Yes	01	
		No	02	
	(iii) Female for kind	Yes	01	
		No	02	
	(iv) Male	Yes	01	
		No	02	
	(v) Eunuch	Yes		
		No		
8	Alcohol consumption	At least once a week	01	
		Less often	02	
		Never	03	
9	HIV or AIDS knowledge – Which of the following can transmit HIV?	Sexual intercourse	01	
		Mouth-to-mouth kissing	02	

No.	Questions	Coding Categories		
		Touching	03	
		Infected blood	04	
		Mosquito bites	05	
		Infected needles	06	
		Sharing toilet	07	
		Mother to child	08	
		Sharing utensils	09	
		Barber's blade	10	
		Sharing clothes	11	
10	Perception of risk of sex with regard to contracting HIV			
	Female for money	Low	01	
		Medium	02	
		High	03	
	Female for kind	Low	01	
		Medium	02	
		High	03	
	Non-commercial	Low	01	
		Medium	02	
		High	03	
11	Beliefs or myths about how to tell if someone has HIV or AIDS	Blood test	01	
		Doctor	02	
		Looks weak	03	
		Weight loss	04	
		Continuous high fever	05	
		Spots on skin	06	
		Body pale	07	
		Tuberculosis	08	
		Diarrhoea	09	
12	Suffered from Sexually Transmitted Infection in past 12 months	Yellowish discharge	01	
		Watery discharge	02	
		Itching around genitals	03	
		Burning pain	04	
		Pain during intercourse	05	
		Genital ulcers	06	
		Swelling in genitals	07	
		Swelling in groin	08	
		Blood in urine	09	
		Failure to pass urine	10	
13	Treatment for Sexually Transmitted Infection in past 12 months	Visited government doctor	01	
		Visited private doctor	02	
		Other treatment	03	
14	Condom usage	Last time had sex	01	

No.	Questions	Coding Categories		
		Every time in last 3 months	02	
		Every time in last year	03	
		Intend to use next time	04	
		Do not intend to use next time	05	
15	Condoms used with which partners	Commercial for money	01	
		Commercial for kind	02	
		Non-commercial	03	
		Male	04	
		Eunuch	05	
16	Factors which make using condom difficult	_____		
17	Attitudes towards condoms	Shows lack of trust in partner	01	
		Breaks easily	02	
		Diminishes pleasure	03	
		Only to be used if you have a disease	04	
		Macho men don't use it	05	
		Forget to use after drinking	06	
		Uncomfortable doesn't fit	07	
18	HIV Testing	Important to know one's status	01	
		Not important to know one's status	02	
		Intends to get an HIV test	03	
		Does not intend to get an HIV test	04	

## ANNEXURE 2

### Mapping Methodology

Preliminary and detailed mapping studies provide information on the presence of migrant workers who engage in high risk behavior, so as to accurately determine target group size and area coverage for effective field communication, two integral aspects of designing an evidence-based Targeted Intervention.

#### PRELIMINARY MAPPING:

##### Objectives

A preliminary mapping study serves to acquire a geographic breakdown of the intervention area, as well as to gain insight into:

- (a) The basic ethnic, religious and cultural background of its population;
- (b) The various congregation points of high risk men;
- (c) The presence of sex workers;
- (d) The presence of various elements such as video parlours, mandals, Non-Governmental Organisations, temples, hotels, lodges, bars and movie theatres that could be vantage points for target-efficient field communication.

The preliminary mapping provides a general overview of the entire geographic area, and is the basis to accurately refine structured methods and tools needed to conduct a detailed mapping study.

### Methodology:

Time period: 5 weeks

1. Outreach Workers are intensively trained on the methodology of conducting the study and familiarised with the mapping tool conducted in the area;
2. Outreach Workers are provided with a map of the intervention area;
3. Outreach Workers initially cover the entire area on foot or by vehicle to observe and gain preliminary insight into the geographic characteristics of the area, as well as to cursorily identify locations of the different elements;
4. In accordance with the map and their initial observations, Outreach Workers demarcate the area into distinct closed areas or clusters for convenience of coverage to conduct the preliminary mapping tool;
5. Subsequently, Outreach Workers visit each cluster, in which they;
6. Sketch the geographic location of the cluster;
7. Interview three Key Informants in each cluster utilising the mapping tool (ensuring three responses to each question in the tool).

The Key Informants in each area include shopkeepers, cinema hall employees, slum residents, housing colony residents, slum development officers, Brihanmumbai Municipal Corporation officers, private doctors, government hospital doctors, Non-Governmental Organisations, industry employers and employees, bar owners and clientele, railway station masters and bus depot in-charges.

### DETAILED MAPPING

#### Objectives:

In order to ensure a target-efficient, streamlined field intervention among migrant workers, a detailed mapping study is conducted, focusing on:

1. An assessment of the target group size of high risk men in the intervention location
2. Identification of target-efficient hotspots or strategic locations for field communication
3. Identification of scope of coverage at existing hotspots
4. Determination of a possible range of field communication activities to be conducted at hotspots
5. An assessment of the presence of Commercial Sex Workers in the area and type of sex work conducted

#### Methodology:

Time period: Approximately one month to six weeks for each component

Outreach Workers are intensively trained on the methodology of conducting the study and familiarised with the different mapping tools conducted in the area, to ensure that they interview at least eight respondents in one day.

The detailed mapping tool is developed based on the observations of the Outreach Workers as well as the different responses of the Key Informants in the preliminary mapping study.

The detailed mapping has four primary components:

1. A **detailed mapping tool** to gain information on target group size as well as congregation points of high risk men (**see Annexure 4**);

2. A **Commercial Sex Worker assessment** to gain information on sites of sex work as hotspots for field communication activity (**see Annexure 5**);
3. A **screening of hotspots, including mandals and video parlours**, to gain information on high risk men and potential types and frequency of field communication activities (**see Annexures 6 and 7**);
4. A **drainage assessment** to avoid overexposure or underexposure of the target group to field communication activities.

### **Component 1 – Assessment of Target Group Size and Congregation Points**

1. Outreach Workers map each lane in the area and demarcate the geographic area into six clusters, based on the preliminary mapping as well as on more detailed observations on foot or by vehicle;
2. Each cluster is further divided into smaller pockets, based on local names of respective areas;
3. In each smaller pocket, Outreach Workers conduct detailed mapping using the tool with three Key Informants, to ensure that each question in the tool has three responses.
4. In each smaller pocket, Outreach Workers observe and identify the total number of structures (counting each structure in each lane), as well as the proportion of structures that house single men and those that house men in families;
5. In each smaller pocket, Outreach Workers interview three Key Informants to assess the number of men living in single-men households and the number of men living in family households;
6. The target group size is calculated according to the following formula
7.  $(\text{Average number of family-men structures} \times \text{Average number of men in family household}) + (\text{Average number of single-men structures} \times \text{Average number of men in single-men household})$ ;
8. In each smaller pocket, Outreach Workers observe and identify the number of mandals, video parlours, sex work spots (including hotels, lodges and bars where sex work takes place), saloons, bhissis, daily labour job posting points as well as tea and paan stalls. Each element has a separate component in the detailed mapping questionnaire. In each pocket, for each element, Outreach Workers collect responses from three Key Informants, based on the questions in the detailed mapping tool.
9. In each smaller pocket, Outreach Workers observe and identify the number of congregation points of high risk men to ensure targeting efficiency with regard to field communication;
10. The Key Informants in each smaller pocket include shopkeepers, cinema hall employees, slum residents, housing colony residents, slum development officers, Brihanmumbai Municipal Corporation officers, private doctors, government hospital doctors, police, Non-Governmental Organisations, industry employers and employees, bar owners and clientele, railway station masters and bus depot in-charges.

### **Component 2 – Commercial Sex Worker Assessment**

1. In each smaller pocket, Outreach Workers interview three Key Informants to gain insight into the location of sex work spots, average rates charged by Commercial Sex Workers for sexual encounters, types of sex work in the area, the manner in which clients approach Commercial Sex Workers, and work timings of Commercial Sex Workers.
2. The assessment can provide insight into whether male residents visit Commercial Sex Workers within the target area or frequent red light areas outside the target area.
3. If there are no visible sex work sites, Outreach Workers can consult with any Non-Governmental Organisations that have established focused interventions with Commercial Sex Workers. These can assist in providing an estimation of the total number of sex work sites as well as the types of sex work occurring at these sites.

### **Component 3 – Screening of Mandals and Video Parlours:**

1. In addition to the information on the number of mandals and video parlours and their basic characteristics provided in the main detailed mapping tool, Outreach Workers can conduct a detailed screening of these elements to assess their suitability with regard to communication programming;
2. A detailed screening tool should be conducted for each video parlour and mandal situated in each smaller pocket;
3. **Video Parlours** – Outreach Workers conduct in-depth interviews with patrons and owners of each video parlour, using separate tools for owners and patrons (**see Annexures 6 and 7**). The questionnaire developed for patrons is quantitative, and the questionnaire developed for owners is qualitative. The latter also highlights the types of shows, number of shows on a daily basis, and the average number of patrons at each show;



4. **Mandals**– Outreach Workers conduct in-depth interviews with presidents of mandals using the screening tool developed (**see Annexure 4**).

#### Component 4 – Drainage Assessment

The detailed mapping tool can provide refined information on target-efficient hotspots. However, it may remain unclear whether the men who frequent these different spots are from the same area (i.e. the same group frequenting different spots) or from different areas. To assess this possible duplication, the following steps are necessary:

1. First, current field communication locations are marked on a map of the intervention area. Then Outreach Workers try to assess, for each particular spot, the predominant areas from which the target group members arrive, showing the drainage from various areas at that particular spot. These areas are marked on the map as areas that are being reached through current communication activities;
2. This assessment provides information on areas where there is overlap and consequently overexposure to field communication activities, as well as areas of non-drainage (areas that are not being reached at all). In areas of overexposure, the frequency of field communication activities can be reduced. Targeted Interventions should be initiated for areas that are underexposed to field activities.

## ANNEXURE 3

### Preliminary Mapping

#### Location:

Draw a map of the geographical location (3 km radius, keeping the clinic as the centre).  
Specify landmark to make the map.

1. Which is the nearest railway station in this area and how far away is it?
2. Which is the bus depot in this area and how far away is it?
3. How many markets are there in this area? List those names and number of shops.

Respondent 1		Respondent 2		Respondent 3	
Markets	No. of shops	Markets	No. of shops	Markets	No. of shops

4. How many cinema halls are there in this locality? List those names.

Respondent 1		Respondent 2		Respondent 3	
Cinema halls	No. of shows and people	Cinema halls	No. of shows and people	Cinema halls	No. of shows and people

5. Are there any slums in the area? Please list their names.

Respondent 1		Respondent 2		Respondent 3	
Name of slum	No. of houses and population	Name of slum	No. of houses and population	Name of slum	No. of houses and population

6. Are there any residential colonies in the area? Please list these.

Respondent 1		Respondent 2		Respondent 3	
Name of colony	No. of houses and population	Name of colony	No. of houses and population	Name of colony	No. of houses and population

7. Is there any industry in the area?

Respondent 1		Respondent 2		Respondent 3	
Name of industry	Shift and No. of employees	Name of industry	Shift and No. of employees	Name of industry	Shift and No. of employees

8. How many bars are there in this locality? If possible please list those names.

Respondent 1		Respondent 2		Respondent 3	
Name of bar	No. of clients in a day	Name of bar	No. of clients in a day	Name of bar	No. of clients in a day

9. Is there any RLD nearby? List those names.

Respondent 1		Respondent 2		Respondent 3	
Name of RLD	No. of CSWs	Name of RLD	No. of CSWs	Name of RLD	No. of CSWs

10. Is there any Non-Government Organisation working in the area? List those names.

Respondent 1		Respondent 2		Respondent 3	
Name of Non-Government Organisation	Transgender they work with	Name of Non-Government Organisation	Transgender they work with	Name of Non-Government Organisation	Transgender they work with

11. Is there any other point where adult males come together in the area? List those places. (Video Parlours, *bissi*, daily labour job posting points, etc.)

Respondent 1		Respondent 2		Respondent 3	
Type and No.	No. of men	Type and No.	No. of men	Type and No.	No. of men

12. Is there any Truck Terminal, Auto or Taxi Stand, mechanic garage? List those places.

Respondent 1		Respondent 2		Respondent 3	
Type of halt point	No. of vehicles	Type of halt point	No. of vehicles	Type of halt point	No. of Vehicles

13. Other Information

- (a) Type of work;
- (b) Language;
- (c) Religion.

Note: Key Informants for preliminary mapping include:

- (a) Shopkeepers in the market;
- (b) Cinema hall employees;
- (c) Residents of slum;
- (d) Resident of housing colonies;
- (e) Slum development office;
- (f) Brihanmumbai Municipal Corporation office;
- (g) Private doctor;
- (h) Government hospital doctor;
- (i) Non-Governmental Organisations;
- (j) Industry people: Employee and employer;
- (k) Bar: owner and clients;
- (l) Railway station master;
- (m) Bus depot in-charge.

**ANNEXURE 4****Detailed Mapping****1. Cluster Number:****2. Name of Locality:****3. Type of Locality: 1. Residential 2. Commercial 3. Residential & Commercial****4. Other \_\_\_\_\_****4. Description of Structures:**

Structure no.	Name of sub-locality	Type of structure	Number of structures	Number of single men staying in structure
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**5. Number of mandals:****6. Number of *bhissis*:****7. Number of video parlours:****8. Number of DLJPP:****9. Number of bars: Number of ladies service bars:****10. Potential spots for our activity:**

Name of spot	Landmark	Type of activity (Suggested)	Average crowd	Transgender background

**11. Mandal Assessment Sheet**

	<b>Respondent 1</b>	<b>Respondent 2</b>	<b>Respondent 3</b>
<b>Name of mandal</b>			
<b>Location</b>			
<b>Registration</b>			
<b>Type of mandal</b>	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal
<b>No. of members</b>			
<b>Type of activity carried out by the mandal</b>			
<b>Area of operation</b>			
<b>Relationship with Non-Governmental Organisations</b>			
<b>Perception of community</b>			
<b>Potential for Targeted Intervention?</b>			
<b>Meeting day and timings</b>			
<b>Chairman &amp; Secretary</b>			
<b>Telephone No.</b>			
<b>Comments</b>			

**12. Video Parlour Assessment**

	<b>Respondent 1</b>	<b>Respondent 2</b>	<b>Respondent 3</b>
<b>Location</b>			
<b>Name of video parlour</b>			
<b>Licensed or non-Licensed</b>			
<b>Number of theatres</b>			
<b>Average shows or day per theatre</b>			
<b>Average audience or show or theatre</b>			
<b>Peak show days</b>			
<b>Peak show timings</b>			
<b>Average audience or show or theatre at peak show</b>			
<b>Language of movies and Type of films shown</b>	a) Family b) Hindi Erotic c) English Erotic d) English Action	a) Family b) Hindi Erotic c) English Erotic d) English Action	a) Family b) Hindi Erotic c) English Erotic d) English Action



---

**Type of audience**


---

**Area from where audience comes**


---

**Willingness to participate in Targeted Intervention**


---

**Potential for Targeted Intervention activity?**


---

### 13. Labour Job Posting Points

	Respondent 1	Respondent 2	Respondent 1
Location			
Number of labourers standing at a time	Men = Women =	Men = Women =	Men = Women =
Timings of gathering			
Peak time			
Type of workers			
Workers' area of residence			
Average amount of time workers stand at the spot			

### 14. *Bhissi* Assessment

Name of the <i>bhissi</i>	Respondent 1	Respondent 2	Respondent 1
Proprietor			
Location			
No. of people eating (A)			
No. of <i>dabbas</i> sent out (B)			
Total (A+B)			
Clients basically from the area			
Timings of eating			
Willingness to participate in Targeted Intervention			

### 15. Other areas of high male congregation:

#### 16. Saloons with more than 3 chairs:

- 1.
- 2.
- 3.

#### 17. *Pan Bidi*+ tea stall (More than 7 people standing at a time)

- 1.
- 2.
- 3.

Opinion 1	Opinion 2	Opinion 3	Opinion 4	Opinion 5	Opinion 6	Opinion 7	Opinion 8
Location							
Type of spot							
Commercial Sex Worker staying at the spot?							
Type of Commercial Sex Worker (Practice At same place, outside)							
Commercial Sex Worker staying with?							
Number of Client Or Commercial Sex Worker or day							
Number CSW							
Activity place							
Number of fixed Clients or Commercial Sex Worker							
Clients from area							
Activity rate							
Other: Modus Operandi:							

## Female Sex Workers Assessment

[illegible]

[illegible]

11. Among the people who come to watch any particular show, what proportion of them comes back for another show?
12. Is there a day in the week when a large number of people come in comparison to other days? Is there any particular reason behind it?
13. Is there a time during the day when a large number of people come in comparison to other times? Is there any particular reason behind it?
14. How frequently you do change the movies, i.e. for how many days generally do you show a particular movie?

## ANNEXURE 7

### Hotspot Screening (Patrons)

The table below gives an example of the kinds of questions used to gather information about migrants who frequent a hotspot and their relationship to it. The example in this case is a video parlour, but similar information could be elicited from a different kind of hotspot, with a modified questionnaire. The factors to be investigated at any hotspot are:

- (i) Age and educational background
- (ii) Geographic and linguistic origin
- (iii) Occupation and income
- (iv) Length of time in present location, and whom residing with
- (v) Timings and frequency of visits to hotspot, reasons for doing so and particular interests there
- (vi) Whether frequenting other hotspots
- (vii) Frequency of sexual behaviour during past 3 months
- (viii) Sexual partners and locations of sex

The script below is for guidance only; as the Outreach Worker establishes a rapport with the interviewee, the real-life conversation can flow more naturally. However, it is important for the Outreach Worker to have a checklist of relevant questions so that he or she does not forget to ask for all the necessary information.

Name of Video Parlour	Code	Movie Timings									
	01										
	02										
	03										
	04										
	05										
	06										
	07										
	08										
	09										
	10										

Date \_\_\_\_\_ ID CODE \_\_\_\_\_

START TIME

Day \_\_\_\_\_

END TIME

Name of Interviewer \_\_\_\_\_

Section 1: BACKGROUND																		
No.	Questions	Coding Categories																
1	Could you please tell me how old you are now?	Age _____																
2	Could you please tell me to which level you have studied?	<table border="1"> <tr> <td>Illiterate</td> <td>01</td> </tr> <tr> <td>Literate but no schooling</td> <td>02</td> </tr> <tr> <td>Primary (1-4)</td> <td>03</td> </tr> <tr> <td>Middle (5-7)</td> <td>04</td> </tr> <tr> <td>Secondary (8-10)</td> <td>05</td> </tr> <tr> <td>Higher Secondary (11-12)</td> <td>06</td> </tr> </table>	Illiterate	01	Literate but no schooling	02	Primary (1-4)	03	Middle (5-7)	04	Secondary (8-10)	05	Higher Secondary (11-12)	06				
Illiterate	01																	
Literate but no schooling	02																	
Primary (1-4)	03																	
Middle (5-7)	04																	
Secondary (8-10)	05																	
Higher Secondary (11-12)	06																	
3	Could you please tell me, what is your occupation?																	
4	Which language do you speak?	<table border="1"> <tr> <td>Marathi</td> <td>01</td> </tr> <tr> <td>Hindi</td> <td>02</td> </tr> <tr> <td>Tamil</td> <td>03</td> </tr> <tr> <td>Telgu</td> <td>04</td> </tr> <tr> <td>Malayalam</td> <td>05</td> </tr> <tr> <td>Urdu</td> <td>06</td> </tr> <tr> <td>Other _____</td> <td></td> </tr> </table>	Marathi	01	Hindi	02	Tamil	03	Telgu	04	Malayalam	05	Urdu	06	Other _____			
Marathi	01																	
Hindi	02																	
Tamil	03																	
Telgu	04																	
Malayalam	05																	
Urdu	06																	
Other _____																		
5	Could you please tell me which State you are from?	<table border="1"> <tr> <td>Maharashtra</td> <td>01</td> </tr> <tr> <td>Andhra Pradesh</td> <td>04</td> </tr> <tr> <td>Tamil Nadu</td> <td>05</td> </tr> <tr> <td>Karnataka</td> <td>06</td> </tr> <tr> <td>Kerala</td> <td>07</td> </tr> <tr> <td>Uttar Pradesh</td> <td>08</td> </tr> <tr> <td>Bihar</td> <td>09</td> </tr> <tr> <td>Other _____</td> <td></td> </tr> </table>	Maharashtra	01	Andhra Pradesh	04	Tamil Nadu	05	Karnataka	06	Kerala	07	Uttar Pradesh	08	Bihar	09	Other _____	
Maharashtra	01																	
Andhra Pradesh	04																	
Tamil Nadu	05																	
Karnataka	06																	
Kerala	07																	
Uttar Pradesh	08																	
Bihar	09																	
Other _____																		
6	Where do you stay in this city?																	
7	How long you have been living here?	<table border="1"> <tr> <td>No. of completed years</td> <td></td> </tr> <tr> <td>If less than 1 year</td> <td>00</td> </tr> <tr> <td>Since birth</td> <td>97</td> </tr> </table>	No. of completed years		If less than 1 year	00	Since birth	97										
No. of completed years																		
If less than 1 year	00																	
Since birth	97																	
8	With whom do you stay?	<table border="1"> <tr> <td>Alone</td> <td>01</td> </tr> <tr> <td>With wife</td> <td>02</td> </tr> <tr> <td>With parents or parents-in-law</td> <td>03</td> </tr> <tr> <td>With friends</td> <td>04</td> </tr> <tr> <td>With relatives</td> <td>05</td> </tr> <tr> <td>With co-worker</td> <td>06</td> </tr> <tr> <td>With wife and parents</td> <td>07</td> </tr> <tr> <td>Others _____</td> <td></td> </tr> </table>	Alone	01	With wife	02	With parents or parents-in-law	03	With friends	04	With relatives	05	With co-worker	06	With wife and parents	07	Others _____	
Alone	01																	
With wife	02																	
With parents or parents-in-law	03																	
With friends	04																	
With relatives	05																	
With co-worker	06																	
With wife and parents	07																	
Others _____																		
9	Could you please tell me , whether you are - _____? (Use one code only)	<table border="1"> <tr> <td>Single</td> <td>01</td> </tr> <tr> <td>Married</td> <td>02</td> </tr> <tr> <td>Divorced</td> <td>03</td> </tr> <tr> <td>Widower</td> <td>04</td> </tr> </table>	Single	01	Married	02	Divorced	03	Widower	04								
Single	01																	
Married	02																	
Divorced	03																	
Widower	04																	



10	What is your average monthly income?	Up to Rs. 1500	01
		Rs. 1501 to Rs. 2000	02
		Rs. 2001 to Rs. 5000	03
		Rs. 5001 to Rs. 8000	04
		Refuse to say	05
		No income at all	06

Section 2: RELATIONSHIP TO HOTSPOT			
No.	Questions	Coding Categories	
11	In a week, how many times do you watch movies in this parlour?	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	
12	In a week, on which days do you come to this video parlor? (Multiple answers possible)	Monday	01
		Tuesday	02
		Wednesday	03
		Thursday	04
		Friday	05
		Saturday	06
		Sunday	07
		Holidays	88
		No specific day	99
13	Which shows do you prefer to watch?		
14	What type of movie do you generally prefer to watch?	Romantic Film	01
		Horror Film	02
		Comedy Film	03
		Blue Film (Erotic Film)	04
		Action Film	05
		Other	
15	How much time it takes to reach this video parlour from the place you stay?	<div style="border-bottom: 1px solid black; width: 150px; height: 20px; margin: 0 auto;"></div>	
16	Do you go to other parlours to watch movie other than this video parlour?	Yes	01
		No	02 → Q21
17	Where are these parlours located?		
18	How many times in a week do you go to other video parlours?	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	

19	Which days do you go to watch movies at these video parlours? (Multiple answers possible)	Monday	01	
		Tuesday	02	
		Wednesday	03	
		Thursday	04	
		Friday	05	
		Saturday	06	
		Sunday	07	
		Holidays	88	
		No specific day	99	
20	Which shows do you prefer to watch in those video parlours?			

SEXUAL BEHAVIOUR				
Introduction: Now I will ask you few questions related to your sexual behavior in the past 3 months. Whatever information you provide will be kept confidential.				
No	Questions	Coding Categories		
21	Have you ever had sex in the last 3 months?	Yes	01	Continue
		No	02	Thank and terminate
22	Think about the female sexual partners you've had in the last 3 months. Would you say they were  <b>"REGULAR" PARTNERS-</b> Wife(s)  <b>"COMMERCIAL" PARTNERS</b> – Partners with whom you had sex in exchange for money  <b>"NON-COMMERCIAL" PARTNERS</b> – Sexual partners you that you are not married to and did not pay, such as fiancée, girlfriends, mistress  <b>(DO NOT INCLUDE SPOUSE in this category)</b>			
		<b>REGULAR</b>		
		Yes	01	
		No	02	
		Don't Know	98	
		<b>COMMERCIAL</b>		
		YES	01	Q23
		No	02	
		Don't Know	98	
		<b>NON-COMMERCIAL</b>		
		YES	01	
		No	02	
		Don't Know	98	
No	Questions	Coding Categories		
<b>Instructions: Q23 IS ASKED TO THOSE WHO HAVE CODED '1' IN "COMMERCIAL PARTNER" IN Q22. OTHERWISE, PROCEED TO Q24</b>				
23	Could you please tell us which place(s) you went to to have sex with a Commercial Sex Worker?			
			01	


			02	
			03	
			04	
			05	
24	Some people have sex with women or girls, and others have sex or <i>masti</i> with other men or boys. In the last 3 months, did you have sex or <i>masti</i> with another man or boy?	Yes	01	
		No	02	Q27
25	What type of sex did you have with a male partner? (Multiple answers possible)	Anal Sex	01	
		Oral sex	02	
		Manual sex	03	
26	Could you please tell us where you went to have sex? (Anal sex, oral sex or manual sex)		01	
			02	
			03	
			04	
			05	
27	Some people have sex with men or boys, and others have sex or <i>masti</i> with hijra. In the last 3 months, did you have sex or <i>masti</i> with any hijra?	Yes	01	
		No	02 →	Thank and terminate
28	What type of sex did you have with a <i>hijra</i> partner? (Multiple answers possible)	Anal Sex	01	
		Oral sex	02	
		Manual sex	03	
29	Could you please tell us where you went to have sex with a <i>hijra</i> partner?		01	
			02	Thank
			03	and terminate
			04	
			05	

**ANNEXURE 8****Model HIV or AIDS Workplace Policies****POLICY ON HIV/AIDS**

*We, at Ambuja Parivar, shall strive to inculcate the awareness of HIV/AIDS at the deepest level amongst our employees, contractual workers, their families, truckers and the community around us to prevent its occurrence. Necessary health care assistance shall be extended to those afflicted with assured confidentiality. We will not discriminate against any employee because of this disease and we will provide them treatment with Anti-Retroviral drugs, as and when necessary.*

*A rehabilitation programme for the epidemic with a strong message to eliminate the misconception of social stigma and discrimination would also be launched. A Core committee will be set up to develop and implement HIV/AIDS programme of GACL and suggest policy and programmatic changes as and when necessary.*

*Ambuja will collaborate with International Labour Organization (ILO), State AIDS Control Society and other concerned Organizations to get guidance/technical support in its HIV/AIDS workplace programme.*

  
**Suresh Neotia**  
Chairman

*Place: New Delhi*  
*Date: 17.08.2004*

**GUJARAT AMBUJA CEMENTS LTD.**  
248, Okhla Industrial Estate, Phase-III, New Delhi-110020, INDIA.  
Tel. : 91-11-51613001, 26327632 Fax : 91-11-51613929, 26848007  
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E-mail:

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### Transport Corporation of India (TCI) - Group POLICY ON HIV / AIDS

TCI Group recognizes that HIV/AIDS can have adverse impact on the workers, families, communities and society at large. TCI, through TCI Foundation is already engaged in implementing an HIV/AIDS intervention programme for truckers.

We, as a proactive employer are committed to prevent the epidemic, provide care to those infected and affected by HIV/AIDS and make a difference to the industry and sphere in which we operate.

The components of our policy are as below:

- (1) *We will not undertake or insist on pre-employment testing for HIV.*
- (2) *We will not discriminate against employees infected or affected by HIV/AIDS*
- (3) *Employees' HIV status will be maintained with utmost confidentiality*
- (4) *We will enable our employees with HIV related illnesses to work for as long as they are medically fit in executing their official duties*
- (5) *We will promote prevention efforts through information and education among our employees, vendors, operating crew and others connected with us in our business, thus ensuring HIV/AIDS education is provided to each and every worker, and their families.*
- (6) *We will extend required support to the affected individuals in mitigating their suffering.*
- (7) *We will treat HIV/AIDS like any other serious illness and provide treatment and support as per TCI medical policy*

The committee convened by Mr. A.K. Bansal, will also review the policy components and their implementation from time to time and make necessary revisions.

TCI will collaborate with the International Labour Organization (ILO), and other agencies for technical assistance in implementing its workplace programme on HIV/AIDS.

Date: December 7, 2005

Place: Gurgaon

**D P AGARWAL**  
Vice Chairman &  
Managing Director



K. Sujatha Rao

Additional Secretary &amp; Director General

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India

NARCO

Dated the 18<sup>th</sup> April 2006

**Subject : NACO guidelines for strengthening the HIV/AIDS interventions in the world of work**

## Dear Colleagues

As you may know, protecting workforce is identified as a key priority by the National Council on AIDS, chaired by the Prime Minister.

I am pleased to send you the enclosed guidelines for strengthening the work of work interventions. I am sure you will find these guidelines useful in strengthening the HIV/AIDS response in the world of work and mainstreaming HIV/AIDS in the programmes of Government departments, private sector employees' organizations, trade unions and civil society organizations. I encourage you to widely share these guidelines with relevant State level partners.

There are several policy/training/communication materials developed by ILO India that are available for adaptation and use at your level. The list is included in the guidelines. Please feel free to ask ILO for these materials.

I look forward to receiving your work plans on this component!

With regards

Yours sincerely,

(K. Suresh Rao)

ENCLOSURE AS ABOVE

### All PDs of SACS

RECEIVED

21 Apr 2006

6. p. 10 :

1. Pls. reply to me. Really, Director, etc.

Dr Denis Byrnes, Country Coordinator, UNHCR

[illegible]

Know your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing





## **National AIDS Control Organisation guidelines on Strengthening HIV or AIDS interventions in the world of work in India**

To:

All Project Directors, State or District AIDS Control Societies Health Secretaries, State Governments and Union Territories

The AIDS Policy of the Government of India stresses that *the organised and unorganised sector of industry needs to be mobilised for taking care of the health of the productive sections of their workforce.*

Nearly 90% of the HIV infections have been reported from the most productive 15-49 years age group in India. If urgent efforts are not taken, this will adversely affect workers, their families, enterprise performance and the national economy. India has a working population of around 400 million, 93% of whom are in the informal economy, who are more difficult to reach. These workers are especially vulnerable to HIV or AIDS. Generally, they have low access to health care facilities and low health seeking behaviour. They have either no or low social protection benefits. It is, therefore, necessary to strengthen HIV or AIDS programmes in the world of work in India on an urgent basis.

No organisation can do it alone. This can happen if HIV or AIDS response becomes truly multi-sectoral and HIV or AIDS is mainstreamed in the existing programmes of ministries, government departments, private sector, employers' organisations and trade unions or civil society organisations. To give highest priority to the mainstreaming process, a National Council on AIDS (NCA) has been set up in India, which is chaired by the Prime Minister. The objectives of NCA are:

- (a) To mainstream HIV or AIDS in all ministries and departments by treating it as a development challenge, and not merely a public health problem;
- (b) To provide leadership to mount a multi-sectoral response to combat HIV or AIDS in the country with special reference to youth, women and **the workforce.**

These guidelines are issued with a view to help State AIDS Control Societies and other relevant stakeholders in strengthening HIV or AIDS response in the world of work at the national or State levels.

### **HIV or AIDS workplace policy:**

State AIDS Control Society can assist government departments, private sector, employers' and workers' organisations to develop workplace policy, based on the national policy framework and the guidelines of the International Labour Organization Code of Practice on HIV or AIDS and the world of work. Key principles of the International Labour Organization Code around which policy can be developed are:

*Recognition of HIV or AIDS as a workplace issue, non-discrimination due to HIV status, gender equality, creation of healthy work environment, social dialogue, no HIV screening for the purpose of employment, respecting confidentiality regarding HIV status, continuation of employment relationship as long as a person is fit to work, provision for HIV prevention efforts through education and training of employees and their families, and care and support, including counselling of individuals or families and treatment.*

### **Operational or programmatic issues:**

- (1) State or District AIDS Control Societies should designate a staff member to coordinate workplace interventions at the State AIDS Control Society level. If it is not possible to dedicate a staff member from the existing personnel, a request may be made to National AIDS Control Organisation for seeking approval of a dedicated person to be appointed on contractual basis at the level of the Non-Governmental Organisation adviser.
- (2) State AIDS Control Society should develop a clear work plan, with timeline and budget, which could be presently supported from the inter-sectoral component under the State AIDS Control Society budget. If allocation is not available, State AIDS Control Society should seek funds from National AIDS Control Organisation by sending a work plan along these guidelines. State AIDS Control Society should include this component under the State PIP being prepared for National AIDS Control Programme III. State AIDS Control Society work plan for this component should cover the following areas:

- a. Sensitisation or capacity building programmes for key departments, employers' organisations or chambers, trade unions, starting with main sectors in the states;
- b. Assisting partners in developing their work plans, and supporting them in terms of training or materials or condoms. **Enterprises** should be encouraged to implement their work plans at their own cost. The support from State AIDS Control Society should be technical in nature related to policy development, training of peer educators, provision of communication materials, condoms and facilitating linkages with the Voluntary Counselling and Testing Centres or Sexually Transmitted Infection clinics or Antiretroviral Therapy centres. Enterprises should be encouraged to support the cost of treatment, including treatment with Antiretroviral drugs, for their employees or families as part of their policy. For contractual employees, they can set up linkages with government hospitals or Antiretroviral Therapy Centres or Employee State Insurance Corporation scheme, wherever applicable;
- c. State AIDS Control Society can offer technical as well as financial support for projects of small and microenterprises and trade unions in the formal and informal sectors. It would be critical to identify entry points through industry associations, unions and other bodies' while developing these interventions. State AIDS Control Society can engage their partner Non-Governmental Organisations to help in this process;
- d. State AIDS Control Society should support setting up Voluntary Counselling and Testing Centres in enterprises which have their own clinical set-up. This will enhance the coverage of Voluntary Counselling and Testing Centres in the State;
- e. State AIDS Control Society should also collaborate with the State labour departments, Central Board of Worker's Education and Employees State Insurance Corporation, two key institutions of the Ministry of Labour and Employment Government of India, who are engaged in the HIV or AIDS programme. Employee State Insurance Corporation scheme also covers for Antiretroviral Therapy drugs. However, State AIDS Control Society may like to collaborate with them for training of doctors, so that treatment protocols are correctly followed;
- f. Involvement of People Living with HIV or AIDS is an effective strategy in the advocacy or training programmes which should be implemented in collaboration with the State-level People Living with HIV or AIDS networks. This is also a good strategy for fighting HIV or AIDS related stigma and discrimination;
- g. For covering workers in the **informal economy**, State AIDS Control Society are already supporting mobile and migrant workers through Non-Governmental Organisations in their Targeted Interventions projects. This coverage can be enhanced by carefully mapping the State-specific vulnerable groups and developing composite projects through Non-Governmental Organisations. In addition, some more approaches can be attempted for enhancing coverage. First, mainstreaming HIV or AIDS in the programmes of various government departments or schemes. Second, engaging civil society organisations - Non-Governmental Organisations working in areas like adult education, health, Income generation, etc.- to mainstream HIV or AIDS within their activities. Third, engaging trade unions in their areas where they have their sectoral unions like the agriculture workers unions, postal workers unions, plantation workers unions, transport workers union, construction workers union, etc. Fourth, encouraging corporate sector to cover their contractual workers as well as workers in their supply chains.

#### Technical support or materials for the world of work programme:

State AIDS Control Society can utilise the following set of materials that have been developed by International Labour Organization India to support HIV or AIDS interventions in the world of work:

- (a) The International Labour Organization Code Of Practice, available in English and Hindi, for policy and programmatic guidelines.
- (b) An Indian Employers Statement of Commitment on HIV or AIDS, signed by seven key employers organisations or chambers in India: All India Organisation of Employers, Associated Chambers of Commerce and Industry of India, Confederation of Indian Industries, Employers' Federation of India, Federation of Indian Chambers of Commerce and Industry, Standing Conference of Public Enterprises and Laghu Udyog Bharati. This statement is published along with a working paper on "Enhancing Business response to HIV or AIDS in India- Operational Guidelines with estimated Cost Analysis".
- (c) A Compendium of Workplace HIV or AIDS policies.
- (d) A Training manual for Master Trainers or Peer Educators of enterprises (includes the enterprise-based strategy as well).

- (e) A CD containing an advocacy film for enterprise, training manual, key presentations and collocation of audio-visual spots for enterprise-based programmes.
- (f) A bilingual (English and Hindi) card game for workplace peer educators.
- (g) A training manual for trade unions in English and Hindi, a handbook and a film on role of trade unions on HIV or AIDS in English and Hindi.
- (h) A set of six posters on HIV or AIDS and the world of work.
- (i) A flip book for unorganised sector workers, produced by International Labour Organization and Central Board of Worker's Education.
- (j) A handbook for labour administrators in English, produced by International Labour Organization and V.V. Giri National Labour Institute.

The International Labour Organization materials are available at [www.ilo.org/hivaidsindia](http://www.ilo.org/hivaidsindia). International Labour Organization will be sending a complete set of materials to State AIDS Control Society. The International Labour Organization is also willing to share the text or art work of posters or materials with State AIDS Control Society, which could be adapted or translated into regional languages and replicated by State AIDS Control Society.

## ANNEXURE 9

### Information Collection in Stakeholder Analysis

#### Introduction

Participatory tools are particularly useful when outreach work involves the exchange of sensitive or private information. Groups like migrants and sex workers themselves can give key insights on existing behaviour, attitudes and practices and barriers to safer behaviours. Hence it is worth investing in training Non-Governmental Organisation partners and peers in the basics of participatory techniques. These can be useful not only in the start-up phase but throughout the project cycle when different messages and Behaviour Change Communication need to be planned, designed and developed.

There are many references and guidelines for participatory techniques for collecting quantitative and qualitative data. Some of these are summarised below.

#### Mapping

Mapping is an effective Participatory rural appraisal technique for gathering information that captures the complexity of local situations. It helps locate important landmarks in an area and identifies Key Informants or guides. Mapping permits the rapid assessment and analysis of a particular situation with the goal of providing accurate, timely information that can be used to develop intervention strategies. An important advantage of this method is that it can be used effectively with uneducated target groups.

Mapping can collect information on:

- 1) Exact locations within the clusters in which the target population reside or operate
- 2) Validation of estimates of target population in each intervention site
- 3) Social networks, brothels, truckers halt points, drug-using points, beer bars, lodges, video parlours, and places where street based sex workers operate
- 4) Service facilities such as government or municipal health clinics, family planning clinics, hospitals, Sexually Transmitted Infection or drug abuse treatment centres, primary health care centres, medical colleges, Voluntary Counselling and Testing Centres and other health care facilities. This information can be useful for building a referral network during intervention.
- 5) Traditional and non-traditional outlets which currently stock or sell condoms
- 6) Other outlets or persons or places which are potential condom outlets
- 7) Other infrastructure, e.g. parks and gardens, water tanks, public toilets and private properties

**Mapping Information Form**

City or Town or District Information about Migrant Locations or Sites		
Date		
Name of the town or city		
Name & contact information of the Key Informant		
Key Informant type		
Key Informant gender		
Locations of migrants with estimated numbers		
No.	Place Name	Estimated Number (Range)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
Notes :		
Investigator's signature:		Supervisor's signature:

**Key Informant Interviewing**

Separate interviews can be conducted with Key Informants of the community. This is considered an effective methodology to collect correct information about migrants, as Key Informants are intimately involved with or exposed to them. Key Informants are individuals with special knowledge, status, or communication skills who are willing to share what they know with the intervention team. They usually have direct expert knowledge, or are identified as an expert by others and can give detailed as well as contextual information. They also have a different relationship to the migrant community than the interviewer or researcher in terms of providing information, introductions and interpretations, often on a day-to-day basis, as well as access to observations that an outsider would not normally have.

An illustrative list of who could be productive Key Informant could include:

- (a) Administrators and officials, e.g. lawyers, judges, police, doctors and paramedics, teachers, etc.;
- (b) Street vendors, taxi or auto drivers, traditional healers, youth club members, community leaders, Non-Governmental Organisation personnel, *dhaba* owners, barbers, etc.;
- (c) Members of the migrant community and power brokers, migrants, Female Sex Workers, union and Labour Department officials.

### Key informants Interview Checklist

Date	
Name of town or city	
Name of location or site	
Name & contact information of the Key Informant	
Key informant type	
Key Informant gender	Male: 1      Female: 2
<b>Questions</b>	<b>Probe points for recording answers verbatim</b>
1. What are the main occupations or work of the people living at this location? Are they the usual residents of this place or have they migrated from nearby places or villages?	Probe for the main occupations or work of the people living in this locality
2. Are these migrants mainly males living alone, or do they live with their family?	Probe for the number of male single migrants and also for those living with the family
3. From which areas mainly are the migrants living in this locality?	Probe for their place of origin – in-state or out of state
4. Do you know people who gather in and around this locality in search of employment, who come from the nearby villages and go back to their place of residence in the evening?	Probe whether any daily migrants congregate in this locality
5. Are the migrants living in this locality here permanently (the majority for more than a year or so) or do they come here and go back during particular months or seasons of the year?	Probe for seasonal pattern of migrants who come to live here
6. Do you think that the migrants living in this locality (either male or females) are at risk of getting HIV infection? If so, why do you think so? In your opinion, which behaviours of these migrants make them more vulnerable to getting HIV or AIDS?	Probe for sexual behaviours or drug usage, etc.
7. Do you know any other person(s) who could tell me more about the questions which I have asked you? Please let me know their names and contact addresses.	Write down the names and contact details of these persons.
<b>Validation and recording the numbers of migrants at the location</b>	
8. Total number of the migrants at this location (may be in range)	
9. Males	
10. Females	
11. Males without family	
12. Females without family	

### Secondary Sources

Secondary sources are materials already published or recorded by others (individuals, research institutions and papers, records and registers), including reference works, data from surveys and existing records.



## Focus Group Discussion

Focus group discussion is a method for eliciting qualitative information from a homogeneous group interaction, in order to produce data and insights that would be less accessible without the interaction found in a group. The key concept here is group interaction. Unlike simple group interviews, Focused Group Discussions depend as much on the exchange of ideas among participants as they do on answers to specific questions from the interviewer. In a Focused Group Discussion, the interviewer is in fact called a moderator, underscoring the role of guide and facilitator in the group process.

Focused Group Discussions can be highly effective sources of data for studies that focus on social norms, expectations, values and beliefs. These stimulate people to share their own ideas and debate the view of others. Most Focused Group Discussions have relatively homogenous groups with respect to age, sex and backgrounds, e.g. a group of migrant labourers of the same age and sex, or a group of community influencers from a particular community.

### Checklist for Focused Group Discussion

Discussion points (not questions)	Notes
1. Place(s) of origin of migrants (District, Block, etc.)	
2. Type(s) of work in which migrants are mainly involved	
3. Awareness about HIV or AIDS among migrants	
4. Awareness about Sexually Transmitted Infections	
5. People suffering from Sexually Transmitted Infections and their treatment seeking behaviour	
6. Multiple partners for sex or other extra-marital sexual behaviours	
7. Visits to Female Sex Workers	
8. Homosexual activity	
9. Injecting drug use	
10. Knowledge about condoms	
11. Availability and use of condoms	
12. Any type of sexual harassment heard about by migrants	
13. Any other relevant information	

## In-Depth Interview

The in-depth interview is a qualitative research technique used to get more detailed information on issues which can not be fully elicited from a focus group discussion, e.g. a life history. It is similar to a Focused Group Discussion, but the interview takes place with one individual rather than a group of individuals. The facilitator uses a pre-designed flexible discussion guide, leaving most questions open-ended.

In-depth interviews require an experienced facilitator with the skills to carry an interview by him- or herself to gain maximum information. As with the Focused Group Discussion, the interview is so far as is possible to be recorded manually or by tape recorder after receiving the respondent's permission.



## Individual in-depth interview form

In-depth interview form for migrants(to be filled in while interviewing migrants at the selected locations)	
<b>Migrant profile</b>	
1	How many months per year do you spend in nearby towns or cities like these for work?
2	How many months per year do you spend in your home village
<b>If the above questions do not indicate that the migrant fits the definition for Targeted Interventions, terminate the interview, otherwise continue.</b>	
3	Where are you from? (Village, Mandal or Taluk or Block, District, State – record all of these)
4	For how long have you been migrating (year)?
5	What kind of work do you do in the town or city? (i) Digging (ii) Construction labour (iii) Road laying (iv) Masonry (v) Carpentry (vi) Agricultural labour (vii) Other (specify)
6	Have you currently migrated: (i) With all your family members (ii) Some family members, but not including spouse (iii) Some family members, including spouse (iv) No family members (alone)
7	How do you get work? (i) Stand in <i>naka</i> everyday, trying to get work (ii) Have a fixed arrangement with a contractor for whole period of migration (iii) Have a fixed arrangement with a contractor for some period of migration (iv) Other (specify)
8	What are the major reasons you have come to this specific town or city (over others) as a migrant? (Not reasons for migrating from source, but reasons for choosing <b>this specific destination.</b> )
9	Where do you stay in this town or city? Where do you solicit for work (if you do)?

Knowledge and Behaviour about HIV or AIDS		
10	Have you heard the term HIV or AIDS or both? <b>If yes, continue, otherwise go to 13.</b>	
11	How does HIV spread or how is it transmitted? (i) Mosquitoes (ii) Hugging (iii) Heterosexual practices – penetrative (iv) Kissing (v) Using the same toilet (vi) Blood transfusion (vii) Lesbianism (female having sex with female) (viii) Sharing blades for shaving in barber shop (ix) HIV infected mother to child (x) Oral sex (xi) Sharing same syringes for injections (xii) Heterosexual practices – non-penetrative (xiii) Homosexual practices (xiv) Anal sex (xv) Sharing food	
12	How can we prevent acquiring HIV or AIDS? <b>(Do not prompt)</b> (i) Using sterilised needles (ii) Accepting only HIV tested blood for transfusion (iii) Abstinence (iv) Be faithful to one partner (v) Using condoms (vi) All of the above (vii) None of the above (viii) Don't know	
13	We would like to ask you a sensitive question about sex life... (i) Have you visited a sex worker in the last one month ? (ii) In the last 12 months ? (iii) If you did visit, did you use a condom everytime? (iv) If not, in how many sexual contacts did you use a condom (out of how many contacts during the last one year)? (v) If not in all sexual contacts, why (specify)?	
14	In the last 3 months, have you ever had any problems such as genital ulcer, urethral discharge, swelling in groin, burning urination)? If yes, what did you do? (i) Any treatment? (ii) Where? (iii) Got cured? (iv) Did you have sexual intercourse with anyone while suffering from Sexually Transmitted Infection?	
15	Have you ever used a condom? From where do you procure condoms?	
16	Ask if migrant is married: (i) Do you use condoms when having sex with your wife (whether she is living with you here or when you go back to your place)? (ii) Do you use condoms with your wife in all sexual acts or occasionally?	

## ANNEXURE 10

## Referral Slip

REFERRAL SLIP		REFERRAL SLIP		REFERRAL SLIP	
(Referee's* copy)		(Doctor's copy)		(Patient's copy)	
No:	Date:	No:	Date:	No:	Date:
Name of City:		Name of City:		Name of City:	
State:		State:		State:	
Name of referee:		Name of referee:		Name of referee:	
Designation: PE/ORW/RMP/CARE/.....		Designation: PE/ORW/RMP/CARE/.....		Designation: PE/ORW/RMP/CARE/.....	
Name of person referred:		Name of person referred:		Name of person referred:	
Age _____ Sex M/F/O _____		Age _____ Sex M/F/O _____		Age _____ Sex M/F/O _____	
Mohalla/Slum/Basti/.....		Mohalla/Slum/Basti/.....		Mohalla/Slum/Basti/.....	
Please tick the syndrome		Partner came for treatment: Yes / No		Diagnosis:	
General	RTI/STI			Rx:	
T/SW/M/O		1			
		2			
		3			
		5			
		6			
		7			
HIV/RTI/STI Message		Follow-up date (if required):		Follow-up date (if required):	
				Give to the patient if follow-up required, otherwise put in the box. On follow-up visit if further treatment required then write on Pt's copy and put this in box.	
				Partner came for treatment: Yes / No	

**ANNEXURE 11****Ongoing Assessment of Volunteer Peer Leaders and Migrants****Ongoing Assessment Tool for Volunteer Peer Leaders  
under Migrant Targeted Interventions**

City	State
Occupation of the Volunteer Peer Leader Migrant	Site name
Interviewer name	Date

SI	Questions	Options	
1	Have you heard about AIDS?	Yes .....1	
2	Do you know the ways by which HIV or AIDS cannot be transmitted from one person to another? (Tick all the options spon-taneously provided by the Volunteer Peer Leader)	By shaking hands .....1	
		By mosquito bite ..... 2	
		By sharing food together ..... 3	
		By sharing clothes..... 4	
		By accompanying the infected person...5	
3	Do you know the ways by which HIV or AIDS can be prevented?	Abstinence.....1	
		Be faithful, one partner.....2	
		Use condom in every sexualcontact...3	
		Blood Safety.....4	
		Precaution for needle use.....5	
4	Do you think a healthy-looking person can get AIDS?	Yes ..... 1	
5	How does HIV spread?	HIV infected blood transfusion.....1	
		Sharing of HIV infected needles.....2	
		Unprotected intercourse with HIV infected person.....3	
		HIV infected mother to the infant.....4	
		Other.....5	
6	What is the difference between other Sexually Transmitted Infections and AIDS?	AIDS is not curable .....1	
		Sexually Transmitted Infections are curable .....2	
		Both AIDS & Sexually Transmitted Infections are preventable .....3	
		Other (specify) .....4	
7	Can you describe the steps for correct use of a condom?	Correctly described ..... 1	
8	Do you know the places where condoms can be obtained?	Hospitals.....1	
		Medical shops .....2	
		Health workers.....3	
		Volunteer Peer Leaders.....4	
		Free condom boxes at public place . .5	

Sl.	Questions	Options	
9	As a Volunteer Peer Leader and being associated with the project, how many persons do you contact per week?	Less than 5.....1	
		Less than 10.....2	
		Less than 15..... 3	
		More than 15.....4	
10	Are you aware of any disease of reproductive or sexual tract (Reproductive Tract Infections or Sexually Transmitted Infection)? Can you name any three symptoms of such diseases?	Not aware..... .0	
		Itching..... 1	
		Boils around genitalia.....2	
		Discharge..... 3	
		Ulceration .....4	
		Burning or painful urination.....5	
		Pain during intercourse.....6	
		Warts on genitalia.....7	
		Lower abdomen pain.....8	
		Others (Specify) _____	
11	What advice would you provide to a person who is suffering from a Sexually Transmitted Infection?	Seek treatment from a doctor ..... 1	
		Seek advice from traditional healers... 2	
		Use condoms.....3	
		Complete treatment.....4	
		Others (Specify)_____	
12	Do you refer patients who have some signs or symptoms of Sexually Transmitted Infections?	Yes..... 1	
13	If yes, where do you refer them?	Name of referral places	
14	Do you follow up with the referred cases about their treatment compliance?	Yes..... 1	
		No..... 2	
15	Do you keep condoms for distribution (Free supply & SM)?	Yes..... 1	
		No..... 2	

**Ongoing Assessment Tool for Migrants within Targeted Interventions**

Sl.	Questions	Options
1	Have you heard about AIDS?	Yes .....1 No .....2 No response .....3
2	Do you know the ways by which HIV or AIDS cannot be transmitted from one person to another? (Tick all the options spontaneously provided by the Volunteer Peer Leader)	By shaking hands .....1 By mosquito bite .....2 By sharing food together .....3 By sharing clothes .....4 By accompanying the infected person .....5
3	Do you know the ways by which HIV or AIDS can be prevented?	Abstinence .....1 Be faithful, one partner .....2 Use condom in every sexual contact .....3 Blood Safety .....4 Precaution for needle use .....5
4	Do you think a healthy-looking person can get AIDS?	Yes .....1
5	How does HIV spread?	HIV infected blood transfusion .....1 Sharing of HIV infected needles .....2 Unprotected intercourse with HIV infected person .....3 HIV infected mother to the infant .....4 Other .....5
6	Can you describe the steps for correct use of a condom?	Correctly described .....1
7	Do you know the places where condoms can be obtained?	Hospitals .....1 Medical shops .....2 Health workers .....3 Volunteer Peer Leaders .....4 Free condom boxes at public place .....5
8	Are you aware of any disease of reproductive or sexual tract (Reproductive Tract Infections or Sexually Transmitted Infection)? Can you name any three symptoms of such diseases?	Not aware .....0 Itching .....1 Boils around genitalia .....2 Discharge .....3 Ulceration .....4 Burning or Painful urination .....5 Pain during intercourse .....6 Warts on genitalia .....7 Lower abdomen pain .....8
9	From where did you come to know about Sexually Transmitted Infections or Reproductive Tract Infections & HIV or AIDS? (Tick the answers reported by the respondent)	Watched on TV .....1 Listen on Radio .....2 From Poster or Hoarding or wall writings .....3 From Volunteer Peer Leader .....4 From Non-Governmental Organisation staff .....5 News Paper .....6 Registered Medical Practitioners or Quack .....7 Any other (specify) .....



SI	Questions	Options	
10	Did anyone provide you information about HIV or AIDS in the last one month?	Yes ..... 1	
11	If yes, please tell me who provided this information	Government Doctor.....1	
		Nurse.....2	
		Private Doctor.....3	
		PMP.....4	
		Medical stores or pharmacy.....5	
		Volunteer Peer Leader.....6	
		Non-Governmental Organisation worker.....7	
		Friend.....8	
		Family member.....9	
12	Do you keep condoms readily available with you?	Any other (specify) _____	
		Yes.....1	
		No.....2	
		Sometimes.....3	
13	Do you use a condom regularly with all partners?	Yes.....1	
		No.....2	
		Don't use with spouse.....3	
14	Did you use a condom in your last sexual contact?	Yes.....1	
		No.....2	
		No response.....3	
15	Did you suffer from Reproductive Tract Infections or Sexually Transmitted Infection during the last 3 months?	Yes.....1	
16	If yes, where did you seek treatment?	Government hospital.....1	
		Private practitioners.....2	
		Traditional healers.....3	
		Self.....4	
		Did not take any treatment.....5	
		Others (specify) _____	
17	Did you complete the treatment as prescribed by the doctor?	Yes.....1	
18	If no, why did you stop treatment?	Side effects ..... 1	
		Symptom not cured .....2	
		Peer Pressure .....3	
		Monetary problems .....4	
		Others (specify) _____	

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 684.**—मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 की उप-धारा (1) उपबंध करती है कि केन्द्रीय सरकार सामान्यतः उक्त अधिनियम के उपबंधों को कार्यान्वित करने हेतु, उक्त अधिनियम और उसके अधीन बनाए गए नियमों से संगत मार्गदर्शन बना सकेगी;

और उक्त धारा की उप-धारा (2), अन्य बातों के साथ-साथ, केन्द्रीय सरकार को लिंक श्रमिक स्कीम परिचालन मार्गदर्शन, 2018 बनाने के लिए सशक्त करती है;

अतः, अब, केन्द्रीय सरकार मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 (2017 का 16) की धारा 46 द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए इस अधिसूचना से उपाबद्ध अनुसूची के अनुसार "लिंक श्रमिक स्कीम परिचालन मार्गदर्शन, 2018" अधिसूचित करती है।

[फा. सं. टी-11020/50/1999—नाको (पी एंड सी)]  
आलोक सक्सेना, संयुक्त सचिव

New Delhi, the 14th August, 2020

**S.O.684 .**—Whereas sub-section (1) of section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017) provides that the Central Government may make guidelines consistent with the said Act and any rules made there under, generally to carry out the provisions of the said Act;

And whereas sub-section (2) of the said section, *inter alia*, empowers the Central Government to make Link Workers Scheme Operational Guidelines, 2018;

Now, therefore, in exercise of the powers conferred by section 46 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 (16 of 2017), the Central Government hereby notifies the "Link Workers Scheme Operational Guidelines, 2018" as per the Schedule annexed to this notification.

[F. No. T-11020/50/1999-NACO (P&C)]

ALOK SAXENA, Jt. Secy.

**SCHEDULE****LINK WORKERS SCHEME OPERATIONAL  
GUIDELINES****Targeted Interventions Division, 2018**

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**National AIDS Control Organisation****India's voice against AIDS**

Ministry of Health &amp; Family Welfare, Government of India

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राष्ट्रीय एड्स नियंत्रण संगठन

Government of India

Ministry of Health &amp; Family Welfare

National AIDS Control Organisation

### Foreword

Under the fourth phase of the National AIDS Control Program (NACP-IV), the Link Worker Scheme (LWS) has been designed to intensify and consolidate the prevention services, focusing on the at-risk population in the rural areas. The Scheme aims to address complex needs of HIV prevention, care and support, in rural areas through identification and training of field level workforce of Zonal Supervisors, Cluster Link Workers and other stakeholders on issues of HIV/AIDS, gender, sexuality and Sexual Tract Infections (STI). Mobilizing difficult-to-reach, others at risk populations, such as High Risk Groups, to access the public health services for STI, HIV Counselling and Testing Centres (ICTC), Anti-Retroviral Therapy (ART) etc. is a component of the Scheme. Their follow up back to communities is also envisaged. It also seeks to address the issues of stigma and discrimination in rural areas of India.

The present guidelines describe the scientific methods of selecting the most vulnerable villages, and strategies to implement the Scheme by using rich epidemic data which hitherto has limited use for local level planning and implementation.

I take this opportunity to acknowledge the contribution made by the technical experts and Targeted Intervention team at NACO in preparing these guidelines. I would also like to acknowledge SACS, TSUs and District NGOs for their valuable inputs.

I hope that these guidelines will help the SACS, TSUs and Districts NGOs for rolling out the Link Worker Scheme more effectively.

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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जांच पाएं

Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing.



**K B Agarwal**  
IAS  
Joint Secretary

भारत सरकार  
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### Preface


The HIV epidemic in India continues to be heterogenic, especially in terms of its geographical spread. As per the Technical Brief of HIV Sentinel Surveillance (HSS) 2012-13, the declining trend among ANC clients, considered as a proxy for general population, is consistent with India's story of large scale implementation and high coverage during Third Phase of National AIDS Control Programme.

The Scheme envisages to "Reach out to High Risk Groups (HRGs) and other at risk population in rural areas with information, knowledge, skills on STI/ HIV prevention and risk reduction".

The HIV response in rural areas requires a localised approach as it is influenced by the unique socio-culture structures present in these areas. For example, ensuring access to healthcare for PLHIVs and detecting and treating HIV infections become a greater challenge in rural areas because of differing perceptions surrounding issues of sex and sexuality, drug use, and HIV, as well as stigma and discrimination towards the PLHIVs.

Link Worker Scheme aims to meet these challenges by reaching out to rural communities and to saturate their coverage. The scheme is designed to build the competencies of rural communities to take the onus of responding to the epidemic in an informed and responsible manner. Recognising the reach and capacity of the local people, the Link Worker Scheme envisages identifying villages-level personnel to work as Block Level Link Workers. These Block Level Link Workers will play the roles of catalysts, identifying the at risk populations, linking them to appropriate services (such as prevention, testing, care and support) and following up with them on a regular basis.

I am confident that effective implementation of Link Worker Scheme will help us reach out the difficult-to-reach population in the rural area and address their risk and vulnerability to HIV/AIDS. NACO would like to acknowledge the support of Public Health Foundation of India (PHFI) for supporting the development of the operational guidelines.

  
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**Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing**

## Abbreviations

AAP	Annual Action Plan
ANC	Ante Natal Care
ANM	Auxiliary Nurse and Midwifery
ART	Anti Retro Viral Treatment
ARV	Anti Retro Viral
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BCC	Behaviour Change Communication
BDO	Block Development Officer
CBO	Community Based Organisation
CDPO	Child Development Project Officer
CHC	Community Health Centre
CMIS	Computerised Management Information System
DAPCU	District AIDS Prevention and Control Unit
DHS	District Health Society
DOTS	Direct Observed Treatment and Short Term Chemotherapy
DSRC	Designated Sexually Transmitted Infections/Reproductive Tract Infections Treatment Centre
DTO	District Tuberculosis Officer
FGD	Focus Group Discussion
FICTC	Facility ICTC
FSW	Female Sex Workers
Health & FW	Health and Family Welfare
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
ICDS	Integrated Child Development Scheme
ICTC	Integrated counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPC	Inter Personal Communication
KP	Key Population
LFU	Loss to Follow up
LWS	Link Worker Scheme
MIS	Management Information System
MNERGA	Mahatma Gandhi National Employment Guarantee Act
MSDS	Migrant Service Delivery System
MSM	Men who have Sex with Men

MSW	Male Sex Worker
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NACSP	National AIDS Control Support Project
NCR	National Capital Region
NERO	North East Regional Office
NGO	Non Government Organisation
NTSU	National Technical Support Unit
OI	Opportunistic Infections
ORS	Oral Rehydration Salt
OST	Opioid Substitution Therapy
OVC	Orphan and Vulnerable Children
PHC	Primary Health Centre
PLHA	People Living with AIDS
PLHIV	People Living with HIV
PPICTC	Public-Private Partnership ICTC
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RSBY	Rashtriya Swasthya BimaYojana
RTI	Reproductive Tract Infections
SACS	State AIDS Control Societies
SHG	Self Help Group
SNA	Situation Need Assessment
SOP	Standard Operating Procedures
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
STLS	Senior Tuberculosis Laboratory Supervisors
STRC	State Training and Resource Centres
TB	Tuberculosis Bacilli
TG	Transgender
TI	Targeted Interventions
TSG	Technical Support Group
TSU	Technical Support Unit
UC	Utilisation Certificate
UNDP	United Nations Development Programme
UP	Uttar Pradesh
VHND	Village Health and Nutrition Day



## INTRODUCTION

In this chapter, the following areas are covered:

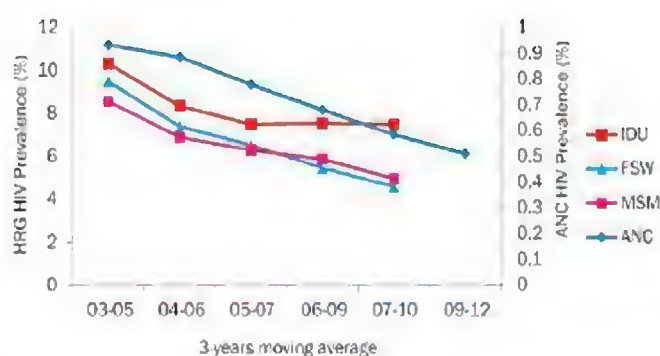
- (i) The key strategies of National AIDS Control Programme-IV and relevance of Link Workers Scheme
- (ii) Objectives, Purposes and Target audiences of the Guidelines
- (iii) Salient features of the Guidelines
- (iv) Services provided under Link Workers Scheme
- (v) Operational definitions used in the Guidelines
- (vi) Organogram of implementation of the Link Worker Scheme

The key strategies of National AIDS Control Programme-IV (part of National AIDS Control Support Project) focuses on intensifying and consolidating **prevention services** with a focus on High Risk Groups and vulnerable population as well as **expanding Information, Education and Communication services** for High Risk Groups with a focus on behaviour change and demand generation and increasing access and promoting **comprehensive care, support and treatment**. These key strategies hold good in a way to consolidate the gains achieved during third phase as well as expand those learning to emerging pockets of epidemic.

The HIV epidemic in India continues to be heterogenic, especially in terms of its geographical spread. As per the Technical Brief of HIV Sentinel Surveillance 2012-13, the declining trend among Antenatal Care clients, considered as a proxy for general population, is consistent with India's story of large scale implementation and high coverage during Third Phase of National AIDS Control Programme.

The HIV Sentinel Surveillance, 2012-13 also highlights that although the overall HIV prevalence continues to be low as 0.35%, there are about 80 sites which shows more than 1% prevalence and 12 sites with more than 2% prevalence. Some of these sites are in the moderate and low prevalence States of Bihar, Chhattisgarh, Gujarat, Madhya Pradesh, Jharkhand, Odisha, Rajasthan, Uttar Pradesh and West Bengal.

Similarly, HIV Sentinel Surveillance 2010-11 highlights that there is significant decline in prevalence among High Risk Groups (i.e. Female Sex Workers, Men Who Have Sex with Men) except in case of Injecting Drug Users the prevalence remains consistent.

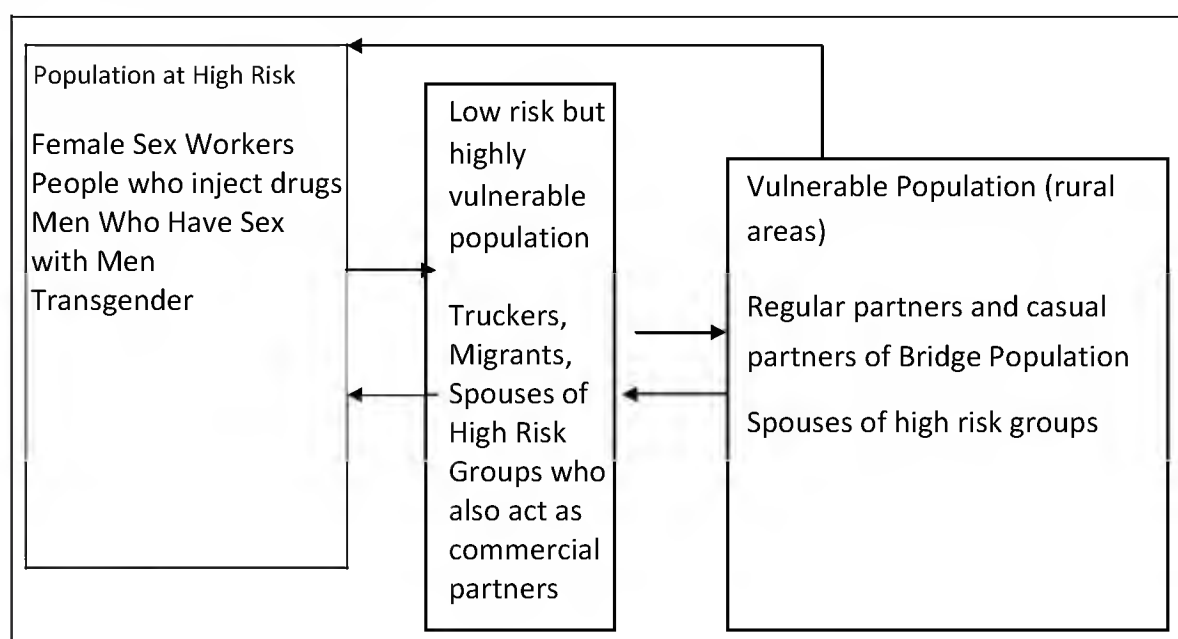


HIV Sentinel Surveillance 2010-11 highlights that some low prevalence States in west, north and east India have demonstrated a stable to rising trend. This rising trend in moderate and low prevalence States is interpreted by the growing understanding for need of high intensity interventions, saturation of coverage of High Risk Groups especially in rural areas, improving access to testing and treatment services. During National AIDS Control Programme-III, National AIDS Control Organisation had invested significant resources and garnered political leadership to bring in these State's capacity and strengthen response.

Although, during National AIDS Control Programme-III, the coverage of Female Sex Workers (81%), Men Who Have Sex with Men (67%) and Injecting Drug User (81%) through a total of around 1821 Targeted Interventions for High Risk Groups and Bridge Population was achieved mainly in urban and peri-urban areas, the coverage of rural High Risk Groups and vulnerable population remained comparatively challenged. During National AIDS Control Programme-III, the coverage and understanding of rural sex-work dynamics, impact of migration related transmission dynamics has evolved through implementation of Link Worker Scheme in selected Districts in India. During National AIDS Control Programme-III by the end of March 2012, the Scheme covered about 1,60,000 High Risk Group, 18,70,000 Vulnerable Population and 37,000 People Living with HIV. Nearly 59% High Risk Groups have been tested at Integrated Counselling and Testing Centre and 58% High Risk Groups have been referred to Sexually Transmitted Infections services under this intervention. This has been done by establishing linkages with existing services. In order to create a sense of ownership in the community and involve the youth in fighting against HIV, 13,296 Red Ribbon Clubs and 21,170 Information Centres had been established at the village level by March, 2012.

From these evidences it is clear that there is a need for comprehensive interventions focusing at community level to reach out rural High Risk Groups and vulnerable population to achieve the accelerated response considering the emerging epidemic drivers in India especially that of rural Antenatal Clinic prevalence being higher than urban Antenatal Clinic prevalence in moderate and low prevalence States (HIV Sentinel Surveillance, 2010-11), spouses of migrants having four times higher risk than non-migrants (Male out-migration: a factor for the spread of HIV infection among married men and women in rural India, PLOS One, September 06, 2012).

The following figure shows the importance of rural High Risk Groups and vulnerable population in the context of HIV transmission dynamics:



The above diagram highlights the fact that until now, the focus on population at high risk and Bridge Population has resulted significant decline, but the emerging epidemic drivers due to



selected groups among general population in rural areas also need to be targeted adequately and comprehensively maintain the responses achieved. This is possible once the interventions are designed and implemented in a community environment by the community volunteers as is being carried out under Link Workers Scheme.

## **OBJECTIVES OF LINK WORKERS SCHEME**

1. The scheme aims at building a rural community model to address the complex needs of rural HIV prevention, care and support requirements in selected geographies.
2. The scheme aims at reaching out to rural population who are vulnerable and are at risk of HIV or AIDS in a non-stigmatised enabling environment.
3. The scheme aims at improving access to information materials, commodities (condoms, needles or syringes) through collaborating with nearest Targeted Interventions or government health facilities, testing and treatment services ensuring there is no duplication of services or resources.
4. The scheme aims at improving linkage to other social and health benefits provided by other line departments in line with local norms, regulations suitable for vulnerable populations.

## **PURPOSE OF THE GUIDELINES**

The purpose of these revised operational Guidelines is to ensure delivery of quality HIV prevention interventions with strong linkage for access to testing and treatment under National Programme for rural High Risk Groups and vulnerable population in selected Districts of India. The Guidelines outline standardised operating procedures for implementing comprehensive HIV prevention services on a scale. In summary the purposes of the Guidelines are:

1. Build in uniform understanding about the need, design and outcomes of prevention interventions among rural High Risk Groups and vulnerable population across all stakeholders, users.
2. Bring in technical competence among implementers, managers and technical support persons.
3. Bring in performance benchmarks and quality interventions to contribute to the National Goal.

## **TARGET AUDIENCE OF THE GUIDELINES**

These Guidelines have been developed for the following audience:

- (i) Policy Makers (Ministry of Health and Family Welfare through National AIDS Control Organisation, Ministry of Women and Child Development, Ministry of Rural Development, Ministry of Panchayati Raj and other line departments).
- (ii) Programme Team of State Level and National AIDS Control Organisation level
- (iii) Implementing partners (Non-Governmental Organisations, Community Based Organisations and Collaborating partners; Staff working in the Targeted Interventions, Integrated Counselling and Testing Centre and Antiretroviral Treatment centres; Private Health Organisations or individual providers etc.)

It is recommended that all organisations using these Guidelines consider each of the proposed elements in the context of the organisation's current environment and other relevant guidelines published by National AIDS Control Organisation.

## SALIENT FEATURES OF LINK WORKER SCHEME

The salient features of this scheme are as follows:

1. The scheme uses evidence-based approach to identify rural areas having greater risk and vulnerabilities of contracting HIV through scientific tools such as Broad Mapping. Individuals/groups within the villages are identified for providing information and services based on detailed Situation Needs Assessments.
2. The scheme envisages creation of demand for various HIV or AIDS related services and the linking of the target population to existing services. The scheme itself does not create any service delivery points.
3. The scheme involves highly motivated and trained community members – preferably a male or female Cluster Link Worker for clusters of villages – who will establish linkages between the community on one hand and information, commodities and services on the other.
4. The scheme envisages creating an enabling and stigma free environment in the project area to ensure that the target population continue to access information, services in a sustained manner.
5. The scheme envisages creating linkages with services of other departments through Accredited Social Health Activist volunteers, Anganwadi Workers, Panchayat heads, Mahatma Gandhi National Employment Guarantee Act scheme officials etc. This is to ensure that the vulnerabilities are identified and addressed by building capacity of ground level stakeholders.

## SERVICES PROVIDED UNDER LINK WORKERS SCHEME

Target Groups	Common Services provided	Specific services
<b>High Risk Groups</b>		
Female Sex Workers Men Who Have Sex with Men	(i) Information and counselling regarding risky behaviour and ways of preventing them. (ii) Condom negotiation skills (iii) Information accessing services for Sexually Transmitted Infections, accessing testing services.	Provision of condoms
People who inject drugs	(iv) Information and counselling related to safe sex practices (v) Information regarding availability of condoms (both free and social marketing) (vi) Referrals and linkages with	(i) Provision of needles and syringes by linking to nearest Targeted Interventions. (ii) Collection of used needles and syringes and processing for bio-medical waste management through nearest Auxiliary Nurse and Midwifery or Primary Health Centre or Targeted Interventions or Integrated Counselling and Testing Centre

	nearest Integrated Counselling and Testing Centre or Facility Integrated Counselling & Testing Centre and follow up of referred cases.	(iii) Information on how to prevent abscess. (iv) Referral to nearest health centre for over dose management, Opioid Substitution Therapy (if available) (v) Provision of condoms
<b>Bridge Population highly vulnerable</b>		
Truckers (local) Migrants (all categories)	(i) Information and counselling regarding the risk of unsafe sex, risk of Sexually Transmitted Infections and importance of syndromic case management (ii) Information regarding condom availability (iii) Information regarding importance of testing services to ensure early detection and access to services.	(i) Provision of condoms (ii) Referrals and linkages to Integrated Counselling and Testing Centre and follow up (iii) Family counselling
Spouses of High Risk Groups who also act as commercial partners	(i) Information and counselling regarding safe sex, condom negotiation skills (ii) Referrals and linkages with Integrated Counselling and Testing Centre and Antiretroviral Treatment centres (iii) Information and counselling regarding Sexually Transmitted Infections or Reproductive Tract Infections and importance of syndromic management (iv) Information regarding availability of condom	(i) Provision of condoms (ii) Follow up for Sexually Transmitted Infections treatment, referral and linkage for syndromic management
<b>Bridge Population with low vulnerability</b>		
Regular partners and casual partners of Bridge Population	(i) Information regarding condom use as triple protection (ii) Importance of Reproductive Tract Infections or Sexually Transmitted Infections, partner management and syndromic management (iii) Information regarding availability of materials, condoms	(i) Partner counselling and referral for Sexually Transmitted Infections check ups, voluntary counselling and testing. (ii) Referrals and follow up for services of Sexually Transmitted Infections, HIV testing and Antiretroviral Treatment (iii) Periodic Health Camps in selected out migration villages

However, under this scheme youth with Sexually Transmitted Infections, with high risk practices, who are known to be clients of High Risk Groups, who are HIV positive or Tuberculosis Bacilli patients, who are on Antiretroviral Treatment are targeted more intensely. Otherwise in general youth are covered through mid or mass media activities.

### Operational Definitions used in the Guidelines

#### High Risk Groups in rural context:

- a. **Female Sex Workers:** Women who sell sex. Includes women who live and practice sex work in the village, women who live in the village but practice sex work outside the village, and women who practice sex work in the village but live outside the village. Excludes women who used to be sex workers in the past and are currently not entertaining clients since last three months. Focus would be on Female Sex Workers who are high volume (more than 8 clients in 15 days) and medium volume (5 to 8 clients in 15 days), those who are highly mobile i.e. travelling at least 10 days a month outside the village. Also Female Sex Workers who are being covered by Targeted Interventions but they visit Targeted Interventions irregularly and there is evidence of services being discontinued.
- b. **Men Who Have Sex with Men:** Men who engage in anal sex with men. Includes men who live and engage in anal sex with other men in the village and with men outside the village and those who have anal sex with men in casual partnerships or in commercial relationships.
- c. **Transgenders (Hijras)** who sell or buy sex with regular or commercial partners.
- d. **Injecting Drug Users:** Injecting Drug Users are defined as those who used any drugs through injecting routes in the last three months. Injecting Drug Users may live and inject drugs in the village, live in the village but inject drugs outside the village, and inject drugs in the village but do not live in the village. Some Injecting Drug Users might be sex workers or Men Who Have Sex with Men and some of them are also female. For Female Injecting Drug Users standard definitions of National AIDS Control Organisation shall be used including services.

**People Living with HIV:** Persons infected by HIV are considered to be high risk in case they do not continue to maintain positive prevention practices. Suppose a positive man continues to have multi-partner sex without condoms.

#### Bridge Population who are highly vulnerable:

- a. **At risk men including clients of Female Sex Workers or Men Who Have Sex with Men:** Includes commercial drivers and cleaners who live in the village and work within or outside the village, migrant workers (single men or women) who come into the village or go outside the village for work/business for a short duration. Excludes long-term migrants who migrate for more than once a year. Includes spouses of Female Sex Workers also.
- b. **At risk women:** Women who have casual multiple partners including Female Sex Workers. Spouses of Men Who Have Sex with Men or Male Sex Workers and Injecting Drug Users who are also High Risk Groups.
- c. **Pregnant Mothers** from the point of vertical transmission and preventing them by ensuring early testing and necessary support during delivery.

**Migrants:** As per the definitions of revised migrant strategy, these are men or women who migrate to high prevalence Districts or towns or cities within or outside the State and have evidence of risk exposure (buying or selling sex; injecting habits based on information from the destination intervention or HIV Sentinel Surveillance). These migrants must be circular and of short duration, thus having the risk of carrying HIV from one place to another.

**Mobile Population:** Significant populations of the village move to nearby towns for work or business and they may come back on the same day or during the weekend. In case it was found that in the nearby town where they move also have High Risk Groups and during discussion with these High Risk Groups it was found that these groups also buy or sell sex during their stay in the town. Then it is important that these groups need to be covered.

**Bridge Population with low vulnerability:**

- a. Partners or spouses of migrant or mobile men and women
- b. Partners or spouses of commercial drivers or cleaners
- c. Men Who Have Sex with Men (not necessarily anal sex)
- d. Injecting Drug Users (not necessarily sharing needles)
- e. Youth Population who have Sexually Transmitted Infections or HIV, who are Tuberculosis Bacilli patients, who are known to be clients of High Risk Groups, who are on Antiretroviral Treatment.

**Cluster Link Worker:** Under this scheme, a person who has been trained and has been made responsible to carry out specific activities is called a Cluster Link Worker. The person can be male or female depending upon the requirements of the District. He or She is expected to reach out to the above groups, link them with services and follow up for continuous uptake of services. Other activities as required are also expected to be carried out by the Cluster Link Workers.

**Target District:** New Districts are to be identified based on the risk and vulnerability parameters provided in the Guidelines. These Districts shall have significant number of High Risk Groups in rural areas (who are high or medium volume and are concentrated in pockets), high out migration with significant positivity among migrants or their spouses, high number of People Living with HIV concentrated in pockets will be considered on priority. In addition Tuberculosis Bacilli incidences and Prevention of Parent to Child Transmission coverage will add in deciding the selection of the District.

**Target Blocks: New or Existing Blocks may be reconfigured based on the following criteria:**

- At least 40% of the villages which are located at least 10 kms (5kms in hilly or Districts with low population density) or more from the head quarter and having significant number of High Risk Groups (who are high or medium volume and are concentrated in pockets), high out migration with significant positivity among migrants or their spouses, high number of People Living with HIV concentrated in pockets.
- One or more Blocks can be clubbed together to make it one cluster for operation may be considered even if these Blocks are from two different Districts. However, the Districts should have only one implementing agency. If separate agencies are available then this cannot be considered.



**Target Area:** The target area would be one village or a number of villages. The selection of village would be based on three basic assumptions.

- 1) Number of pregnant mothers (including spouses of high risk men or women, spouses of migrants) to be covered.
- 2) Number of High Risk Groups (as defined above) and or at least 40% of the households are having short, circular migration.
- 3) Number of Tuberculosis Bacili patients and People Living with HIV in the village or cluster of villages

**Hotspots:** These are solicitation sites of Female Sex Workers, Male Sex Workers, Transgender. These sites may be within a village, along the national highways or in dhabas near the village, at the weekly market place near the village, nearby town, nearby lodges or brothels or any other place which will be beneficial for the programme to reach out and provide information and condoms.

**Hotspot for Injecting Drug Users:** These are places within a site where significant concentration of Injecting Drug Users come together for various purposes including injecting of drugs, taking rest or during crisis events (abuse by family, public or police).

**Sites:** These are congregation points where congregation of above target population occurs for various purposes not necessarily for high risk activities. Every site cannot be a hotspot but each hotspot may also be a site as well.

**Truckers:** In India, these are male who primarily drive trucks. They may start from the originating station, they may board at any place in between the originating and destination points. They may be employed by the transport companies or are on contract basis, however no formal contract exists.

*But for HIV programme point of view in rural areas the truckers (including helpers) are defined as those who are plying trucks in and around the area for various purposes, they may belong to the same village or may be coming to the village for business purposes and having significant risk for HIV.*

**Mid-media:** These are forms of communication where the communicator (Cluster Link Worker, ORW or a group) reaches to more than eight people with contents relevant to the group. However, there is limited participation of the group with the communicator. These may be in the form of skits, plays, musical programmes, games etc.

**Mass media:** Mass media provides a means of expanding programme messages and creating demand beyond the boundaries of the intervention. It has the added advantage of reaching the population outside a formal intervention environment. However, there is no participation of the group with the communicator. These may be in the form of posters, pamphlets, hoardings, short films, short text message, social media etc. These include wall writings, posters, dangles with specific messages.

**Social Marketing of condoms:** In the process, condoms are marketed by outlets in an accessible place in the villages. This can be a paan shop, tea shop, grocery shop or can be an individual. By marketing these condoms the outlet holder makes some profit and this helps him/her motivated to be engaged for a social cause. In rural context, condoms can be marketed with sanitary pads, Oral Rehydration Salt pouches etc.



**Health Camps:** These are specific events organised at Panchayat Level especially during festivals when migrants return to their villages. This helps everybody to get their health checked up as well as undergo HIV counselling and testing. These shall be organised with prior consultation with State AIDS Control Societies and local District Health Society. So that there is no duplication and necessary support can be provided. Ideally the doctors, medicines and Information, Education and Communication the materials, condoms are to be provided by District Health Society and State AIDS Control Societies shall provided testing and counselling support. A detailed guideline on conducting health camps may be referred from State AIDS Control Societies or National AIDS Control Organisation.

**Volunteers and Volunteerism:** In the context of Link Workers Scheme, it is required that the target population get service from other available service points. Hence, the volunteers in this scheme will be Accredited Social Health Activist, Auxiliary Nurse and Midwifery, Anganwadi Worker, Livelihood mission staffs, Watershed project staffs etc. who work or live in the Panchayat. They need to be essentially sensitised and used as a volunteer to link up services. When they link up services and continue to do so, this can be one of the best example of volunteerism. Besides these Self Help Group members, Youth club members can also be taken as volunteers.

**Referral:** When a client is sent to avail a service from a centre, the process is called referral. Usually in Link Workers Scheme, the process may be accompanied by the staff or may be by issuing a referral slip indicating the date and place of referral.

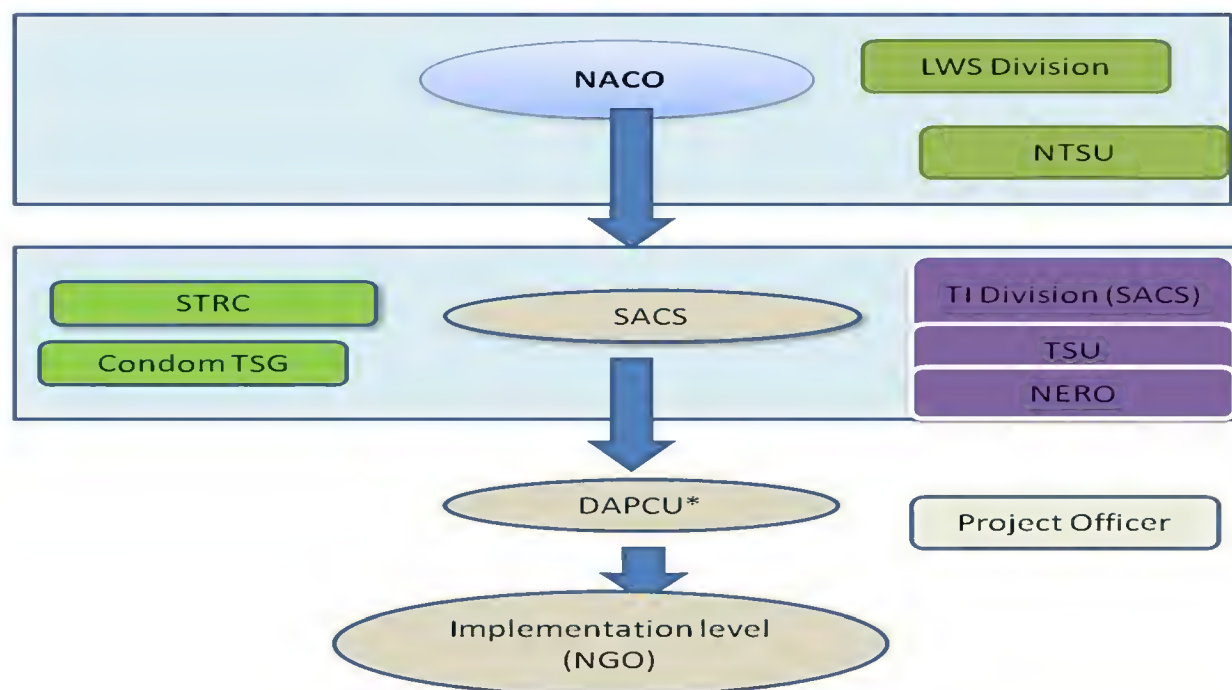
**Linkage:** When a client is linked to any service and is continuously followed up for adherence of services, then the process is called linkage. The linkage monitoring helps to understand the issues those need to be addressed for are improve adherence.

**Contact:** When any target population as defined in these Guidelines is contacted either one to one or one to group for information or services such as provision of condom will be considered as contact. However, in case of contact of High Risk Groups it is mandatory that the Interpersonal Communication tools are to be used for Interpersonal Communication sessions and the used copies of tools are kept in the office by Block supervisor for verification.

**Coverage:** When any target population has accessed clinical services such as Sexually Transmitted Infections clinic visit or Sexually Transmitted Infections treatment, HIV testing or syphilis testing will be considered as coverage.

**Drop out:** If no services are provided as mentioned in the coverage for continuous of three months, then the name of the concerned individual to be dropped from the line list and the total target is updated.

### Organogram of Implementation and Management of Link Workers Scheme:



### Organogram of Implementation of Link Workers Scheme at Non-Governmental Organisation level:

Entities	Major responsibilities
District level NGO	Management support
District Resource Person (1 per district)	Programme Management support
Zonal Supervisor (2 per district)	Supervision, Monitoring, Networking
Cluster Link Workers (maximum 20 per district for 100 villages)	Implementation, Advocacy, Monitoring
M&E cum Accounts Assistant	M&E, Accounting support

## CHAPTER 1

### RATIONALE FOR PREVENTION INTERVENTIONS AMONG RISK AND VULNERABLE POPULATION IN RURAL AREA

In this chapter, following areas are covered:

- (i) The rationale for prevention interventions among risk and vulnerable population in rural area
- (ii) HIV risk among rural population
- (iii) Factors which make rural population to vulnerable for HIV

## **1.1 RATIONALE FOR PREVENTION INTERVENTIONS AMONG RISK AND VULNERABLE POPULATION IN RURAL AREA:**

A central strategy of India's National AIDS and Sexually Transmitted Diseases Control Programme has been to reduce sexual transmission of HIV within high-risk sexual networks, and from these high-risk networks into the general population. Accordingly, National AIDS Control Programme-IV (part of National AIDS Control Support Project) had prioritised HIV prevention among at risk and vulnerable population as a key programme component. During this phase of National AIDS Control Programme-IV (part of National AIDS Control Support Project) the priority to scale up and provide quality services among this population will be taken forefront both in rural and urban areas.

According to the HIV Sentinel Surveillance data there are about 80 Districts with more than 1% prevalence and 12 Districts with more than 2% prevalence have been identified along with about other 100 Districts to improve the epidemic scenario especially among rural general population.

India's success in declining HIV prevalence need to address the inclining or stable trend of HIV in moderate or low prevalence States as well. In these States, the High Risk Group urban mapping data highlights sparsely distributed low volume High Risk Groups (with less number of clients or less than 2 sexual encounters in a week in case of Female Sex Workers and Men Who Have Sex with Men, Transgender). This urban High Risk Group mapping data does not significantly probe into the possible epidemic drivers in these States.

According to a research conducted by National AIDS Control Organisation in association with United Nations Development Programme in Odisha–Gujarat Corridor, Uttar Pradesh–Mumbai, Bihar–Delhi National Capital Region highlights migration being one of the epidemic drivers especially the study indicates that spouses of migrants are four times at risk than the non-migrant spouses.

Further the Integrated Counselling and Testing Centre prevalence in these States especially among general population highlights the need for three levels of challenges:

- To identify, prioritise and implement interventions targeting at risk in an environment where HIV or AIDS is still considered a stigma as well as myth.
- To address between demand and supply gap. As long as the services are not available and accessible any degree of risk perception or awareness about early diagnosis, access to condoms will not result in practice.
- To address the need for improving Tuberculosis Bacili-HIV and reproductive health and HIV related service delivery in an inclusive approach instead of seeing these services as separate entities.

Hence, reaching risky and vulnerable populations with an effective HIV prevention programmes and services is important for a number of reasons. The existing Link Workers Scheme during 2013-14 has reached 1,79,393 High Risk Groups (against a mapped estimate of 1,68,082 High Risk Groups) and 41,11,795 vulnerable population (against a mapped estimate of 45, 99,326 vulnerable population). (Source: Annual Report of National AIDS Control Organisation, 2013-14). This signifies that the presence of significant number of High Risk Groups and vulnerable population in rural areas may be one of the important factors in driving the epidemic. Hence, there is a need for customised package of

services tailor made for rural communities and tuned with their culture and practices, so that the risk and vulnerabilities can be addressed.

## 1.2 HIV RISK AMONG RURAL POPULATION

Among all rural population, from the epidemic transmission point of view, the at risk population are crucial because of following:

1. High Risk Groups in rural areas have heightened risk because of their natural and casual sex partners and in most of the cases a closed sexual network within which they operate.
2. The Bridge Population have significant mobility pattern and hence, they are considered at high risk of transmitting HIV infections across different risk venues and risk partners.

Considering the above the prevention interventions will focus on approaches to reaching out to both rural high risk and vulnerable population with differentiated intensity of interventions. In additions, communication strategy, services will be provided to general population and youth in a project District.

## 1.3 FACTORS WHICH MAKE RURAL POPULATION VULNERABLE TO HIV

The factors affecting rural populations' risk-taking behaviour are varied, but are important in understanding the overall vulnerability to HIV.

- **Low level literacy and limited accessibility to information:** While the level of information among these population related to Sexually Transmitted Infections and HIV or AIDS is relatively high, this information is rarely converted into action. Primarily due to improper understanding or interpretation of information about HIV or AIDS leads to risky behaviour.

Other factors which affect their vulnerability to HIV include:

- (i) High Tuberculosis Bacili incidence and co-infection:
- (ii) Closed sexual networks often lead to quick transmission among these people:
- (iii) Vulnerability associated with social position of women and often being considered as a commodity:
- (iv) Attraction for disposable income and often being pushed into sexual practices out of poverty:
- (v) Prevailing myth about condom use, Sexually Transmitted Infections treatment makes them to seek treatment from quacks, lack of adherence to treatment.

### 1.3.1 Related Groups at Risk for HIV

- (i) With pressure on improving road infrastructure, there is construction of new highways or upgrading the present highways, many migrant labourers have become involved in road construction, and female road workers often also sell sex to truckers. This is often a vulnerability factor for villages nearby.
- (ii) Staff of eating points, Border and Police staff, Transport Workers are also at risk because of their vulnerability and power structures in relation to the High Risk Groups in rural areas.

## Take home messages:

- (i) From HIV programme point of view, the rural High Risk Groups operating in a closed network or those who operate from nearby urban or peri-urban areas are important to be targeted with prevention intervention programmes.
- (ii) Rural High Risk Groups already registered with existing Targeted Interventions but have high degree of mobility between Ti site and nearby rural areas are important in terms of their contribution in spreading the HIV in a closed network.
- (iii) Rural Men Who Have Sex with Men especially those who operate in a social structure often do not open up about their identity and behaviour, these group need to be tapped through the clients who are also accessing heterosexual regular or commercial partners.
- (iv) Their low self-worth, limited knowledge and access to services, peer pressure and peer behaviour makes them vulnerable to various health problems including HIV.
- (v) Availability of services which are non-stigmatised and acceptable to their norms would enhance access.

## CHAPTER 2: Guidelines for State AIDS Control Societies and Technical Support Unit

In this chapter, the following areas are covered:

- (i) Role of State AIDS Control Societies and technical support unit
- (ii) Role of technical support unit Project Officer
- (iii) Defining the target population at risk – WHOM to be targeted under link workers scheme
  - Steps in defining target population at risk in a new or existing District
- (iv) Steps in defining the target area (WHERE) of the Link Workers Scheme in a new District – Broad mapping, site assessment
  - Steps in prioritising the villages or Blocks in an existing District of Link Workers Scheme – Site assessment
- (v) Target settings for coverage of different target groups in a new and existing District
- (vi) Determining availability of services (WHAT SERVICES) are to be planned
- (vii) Capacity building areas of implementing partners
- (viii) Monitoring and evaluation in Link Workers Scheme



## Role of State AIDS Control Societies and Technical Support Unit:

State AIDS Control Society is the key player in providing management and technical support to the Link Workers Scheme programme. In addition Technical Support Unit, State Training & Resource Centre play their respective roles as outlined in this chapter. However in the absence of State Training & Resource Centre and Technical Support Unit, State AIDS Control Societies has to carry out all the functionalities.

### Role of State AIDS Control Societies:

- (i) Contract management and timely fund flow by ensuring that the attrition of link workers is not attributed due to poor fund flow mechanism.
- (ii) Conduct regular bimonthly/quarterly meetings with Link Workers Scheme Non-Governmental Organisations, District AIDS Prevention & Control Units to review and understand field challenges and gaps and provide inputs for any mid course corrections to National AIDS Control Organisation.
- (iii) Conduct field visits to the implementing Districts to review and provide technical inputs to the programme.
- (iv) Ensure coordination amongst all partners working in a particular District especially in terms of High Risk Groups, bridge populations and vulnerable populations.
- (v) Ensure free condoms, Information, Education and Communication materials as per requirement of the scheme is available from the Districts or Block Health Society under National Health Mission.
- (vi) Ensure that the folk troupe activities, condom social marketing campaigns and migrant health camps are conducted in 80% of the project area in a District each year.
- (vii) Consider the mainstreaming of programmes in all Districts covered in the scheme in a synergetic manner so as to address the issue of vulnerability.
- (viii) Ensure that the staff conducting the scheme is trained and their skills are built to implement the activities effectively by the State Training & Resource Centre or any other arrangement where State Training & Resource Centre is not available.
- (ix) Select Implementing Non-Governmental Organisations as per National Guidelines.
- (x) Information, Education and Communication division to plan number of mid-media events, adequate supply of Information, Education and Communication materials, Link Workers Kit for use by the District level Non-Governmental Organisation staff. All Information, Education and Communication related activities are to be carried out in coordination with Information, Education and Communication division of State AIDS Control Societies or National AIDS Control Organisation. These activities shall ideally be planned in the Annual Action Plan to ensure that the District level Non-Governmental Organisations are supplied with the materials as per requirements.

### Role of Technical Support Unit:

In order to ensure uniformity in approach (with local adaptation), quality intervention the role of management and technical teams would be to:

- (i) **In NEW Districts:** Ensure identification of project Districts and villages or cluster of villages and come up with an estimated size of at risk and vulnerable population within a given one to three months of initiation of projects in case of new Districts.



- (ii) **In EXISTING Districts:** While in existing intervention Districts there is a need to prioritise villages/cluster of villages and target population who need to be covered as per the revised norms of this Guidelines.
- (iii) Facilitate State AIDS Control Societies in determining the performance indicators and approaches to be followed for implementation. Establish quality assurance and quality improvement systems.
- (iv) Facilitate capacity building of staff on the implementation approaches.
- (v) Ongoing mentoring support to provide day to day support in implementation especially areas of improvement as the Technical Support Unit staff will be visiting to the Targeted Interventions, Integrated Counselling and Testing Centre, Antiretroviral Therapy centres and may come across with issues related to service gap among rural High Risk Group but registered with nearest Targeted Interventions, high positivity or high number of Antiretroviral Therapy clients from rural areas etc.
- (vi) Provide support in identifying gaps, working out local solutions through regular reviews.
- (vii) Support in conducting bio-behavioural surveys.
- (viii) Facilitate advocacy among allied ministries to bring in sustainability of the approaches suitable to the local conditions.

Evidence Building	<ul style="list-style-type: none"> <li>• Evidence collection about distribution of risk and vulnerability pattern</li> <li>• Identification of target villages and facilitate target setting</li> <li>• Assessment of sample villages or clusters in existing districts</li> </ul>
Planning	<ul style="list-style-type: none"> <li>• Working out individual proposals for each district with clarity on approaches, performance indicators and budget.</li> <li>• Determine approaches with clear cut monitoring indicators.</li> <li>• Facilitate capacity building of implementing agency</li> </ul>
Monitoring	<ul style="list-style-type: none"> <li>• Supportive supervision and review of the proposed approaches</li> <li>• Carry out mid-course correction.</li> <li>• Generate evidences on impact and outcomes</li> </ul>

### Role of Technical Support Unit Project Officer:

The role of Technical Support Unit Project officer is to provide supervisory and mentoring support to the Districts with Link Workers Scheme in his or her area. In the absence of Technical Support Unit, the District AIDS Prevention & Control Unit and State AIDS Control Societies officers have to perform the same functions as mentioned below. The Technical Support Unit Project officer is expected carry out following duties and responsibilities as mentioned below:

- (i) Ensure all staff are recruited by District level Non-Governmental Organisation according to the approved plan and guidelines
- (ii) Ensure the District level Non-Governmental Organisation provide the appointment letter to all staff with detailed Terms of Reference
- (iii) Facilitation for induction training of newly recruited staff by the in house mechanism

- (iv) Ensuring that the District level Non-Governmental Organisation conduct site assessment on regular basis
- (v) Ensure that the District level Non-Governmental Organisation conduct health camps as per the approved plan and in close coordination with State AIDS Control Societies or District AIDS Prevention & Control Unit or District Health Society
- (vi) Ensure District Resource Persons carries out monthly review the performance of the staff and provides support in improving the same
- (vii) Ensure that the District level Non-Governmental Organisation staffs develop referral network for Integrated Counselling and Testing Centre, Care & Support, Tuberculosis management, Sexually Transmitted Infections complications, medical care, social and legal support, Injecting Drug User services
- (viii) Ensure that the District level Non-Governmental Organisation staff have a plan to setup free condom outlets and social marketing as per the Guidelines
- (ix) Ensure that the District level Non-Governmental Organisation utilize the funds in time and as per budget guidelines
- (x) Ensure that the District level Non-Governmental Organisation staff have the correct understanding of all Monthly Reporting indicator
- (xi) Ensure that District level Non-Governmental Organisation timely submit Utilisation Certificates and Monthly Reports to State AIDS Control Societies
- (xii) Ensure that each District level Non-Governmental Organisation receives analytical feedback on their monthly performance as per Monthly Reporting indicators
- (xiii) Ensure that District level Non-Governmental Organisations are adequate stock of Information, Education and Communication materials from State AIDS Control Societies
- (xiv) Facilitation of rapport building with all stakeholders, co-ordination with District AIDS Prevention & Control Unit and other Government agencies for programme support
- (xv) Coordinating with Technical Support Unit and State Training & Resource Centre to ensure all staff are trained
- (xvi) Ensure the following supervisory plan is ensured in a Link Workers Scheme District: (first time visit to any District should be of five days, subsequent each visit should be two to three days, single day visits are not recommended). Ensure that all the Blocks are visited atleast once in six months in case the number of Blocks covered in the District is less than 10.
- (xvii) During each District visit plan to visit atleast one Block and two villages based on the review of the programme – during Block visits meeting with key stakeholders like Block medical officer, Child Development Project Officer, Block Development Officer, Block Pramukh (Panchayati Raj head at Block level) etc.

## 2.1 Defining the Target Population at Risk and Site Assessment

There are no gold standards to the assessment approaches to define the target population at risk and sites where the prevention interventions will be most effective for populations which continue otherwise to remain anonymous in a closed sexual network. In several countries, the approaches have been evolved along with time. There is nothing that fits in for all. This is because of following:

- (i) Risk behaviour of rural High Risk Groups especially Female Sex Workers and their clients is generally drawn from that of the general population of same area from where they belong to. Hence, the socio-demographic features would not be different, but their risk taking pattern will depend upon the vulnerabilities and peer pressure, peer group behaviour.
- (ii) With the changing landscape of the rural areas, with more and more entertainment and business related options available in close by urban and peri-urban areas there is great degree of mobility of

Female Sex Workers or Men Who Have Sex with Men to take part-time jobs and some of them also take up high risk activities as a part of disposable incomes.

- (iii) Similarly, the persons who abuse substances like ganja, alcohol often fall into prey to the local quacks or pharmacies to get habituated for injectable pharmaceuticals. There may be other examples as well. This transition often leads to self experimentation in groups and often leads to people habituated to inject pharmaceuticals or drugs on their own.
- (iv) Limited evidence about the profile of these rural High Risk Groups who take risk, who are HIV positive and require Antiretroviral or those who are taking Antiretroviral and their drug adherence pattern.

This is due to documentation gaps within the existing systems of reporting and evidence informing systems.

Hence, to overcome these challenges there is a need for continuous study at programmatic level to understand following:

- (i) Defining the target population (whether all High Risk Groups or vulnerable population in rural areas are at risk or only those who have more partners, are mobile between places, have high Sexually Transmitted Infections episodes, who are spouses of High Risk Groups are at risk).
- (ii) Defining the relative risk among these target population (defining the risk taking pattern and peer group behaviour (young or old ones), (new or old ones), (at one location or at different locations).
- (iii) Defining the relative risk taking pattern among the most at risk target population (type of sexual behaviour, condom use pattern, injecting pattern, health seeking behaviour, attitude towards less risky behaviour)

Therefore, it is important that the State AIDS Control Societies and Technical Support Unit need to understand some of these above important areas before stepping for developing local evidence based strategies based on the broad strategies discussed in the Guidelines. These understanding are based on past experiences, these may be reviewed and mid-course correction can be brought in with enough evidence.

### **Steps in defining the target population at risk:**

1. Collect People Living with HIV related data from nearest Integrated Counselling and Testing Centre or Prevention of Parent to Child Transmission of HIV or Antiretroviral Treatment or Link Antiretroviral Treatment or Facility Integrated Counselling and Testing Centre or Public-Private Partnership Integrated Counselling and Testing Centre to understand the burden of HIV in the District (whether the same is 10 per 1000 population tested in a specific geographical area).
2. Collect High Risk Group related data from nearest Targeted Interventions (may be located in the neighbouring District or same District to understand what percentage of the High Risk Groups line listed in the Targeted Interventions belong to the rural areas and their mobility pattern, client profile. Also collect information from the clients of High Risk Groups to understand the presence of High Risk Groups in rural pockets of the Block or District.
3. Collect Sexually Transmitted Infections data from nearest Designated Sexually Transmitted Infections or Reproductive Tract Infections Treatment Centre or Primary Health Centre or Community Health Centre or Private practitioners or any other sources which indicate the Sexually Transmitted Infections burden, profile of Sexually Transmitted Infections patients and geographical distribution of these cases.

4. Collect migration related information from Anganwadi Workers or Auxiliary Nurse Midwife or Panchayats or from other recent studies in the District – to highlight the volume of migration, pattern of migration (whether long term, short term), seasonality pattern and HIV or Sexually Transmitted Infections burden from above information.

Based on these information, Technical Support Unit or State AIDS Control Societies is expected to come up with a definition of the target population which is at risk and need to be covered by Link Workers Scheme, especially determining:

- a) High Risk Groups from rural area at risk
- b) Migrants and their spouses are at risk
- c) People Living with HIV burden is high or Sexually Transmitted Infections burden is high or both

## 2.2 Defining the location where the scheme can be implemented

Once we identify the risk groups, then comes the process of identifying the geographies or pockets which need to be targeted with services. Hence for new and existing Districts following steps are to be followed:

Existing Districts to prioritise amongst existing Villages	New Districts OR New Blocks in an existing District
Site assessment	Define the target population at risk
Service mapping	Broad Mapping
	Site Assessment
	Service Mapping

In the HIV or AIDS programming, mapping has significance in terms of its importance in broad planning and resource allocation. But in case of rural prevention programming the house to house survey or preparing point estimates generated through mapping at a given point of time often may not be the best evidence for programming. The mapping estimates may vary with the social milieu of the area about High Risk Groups and high risk behaviour, about the social acceptance of multi-partner sex etc. as well as the place where mapping is being conducted, the purpose and timings during which the mapping is conducted, availability of the target population at risk are being mapped.

Hence, while designing these interventions it is highly recommended to carry out Broad Mapping across the District in sample pockets of the Block with the secondary data sources which suggest presence of significant People Living with HIV load or Antenatal Care HIV positivity or presence of High Risk Groups (atleast 20-30 in a cluster of four to five villages) to understand the possible target village or cluster of village for intervention. This Broad Mapping is to be followed by site assessment in a new District only. In existing Districts only site assessment (NO Broad Mapping) is to be conducted by the implementing agency while working with the communities as a part of their ongoing activities by using specific tools.

To summarise these terms, the following table can be referred:

Activities	Definition	Importance	Where to carry out
Broad Mapping (only in NEW Districts)	Broad Mapping is defined as an activity which provides broad information in a map of limited or wide geographical area indicating concentration and availability of target population.	Gives broad information about the locations where concentration of High Risk Groups or vulnerable population available as defined in this guideline.	Sample pockets of the Block which the secondary data sources suggest presence of significant People Living with HIV load or Antenatal Care HIV positivity or presence of High Risk Groups (at least 20-30 in a cluster of 4-5 villages).
Site Assessment (In both new and existing Districts)	Site assessment is an activity which provides detailed information about the target population in terms of its needs, priorities; about the resources available and about the environment where intervention is proposed.	Gives detailed information about the risk pattern of groups, services available in the area, services to be planned, and resources required.	All villages or cluster of villages with sites which have at least 15-20 High Risk Groups in 4-5 villages or there is seasonal and short term migration to high prevalence States of more than 200 migrants from 4-5 villages or 10 People Living with HIV per 1000 adult population tested in cluster of 4-5 villages.

### Exclusion criteria for both Broad Mapping and Site Assessment:

- (i) Villages within 10 kms (in hilly regions or low population density areas 5 kms) from the Block or District head quarter to which they belong to are to be considered for second priority.
- (ii) Villages (population of more than 5,000) with more vulnerable population but less than 10 high or medium volume High Risk Groups shall be considered as second priority.

Based on these following steps the village or cluster can be selected for prevention interventions.

The Broad Mapping and site assessment will result in following outputs:

1. Establish the expected volume of at risk and vulnerable population in villages or cluster of villages.
2. Establish the key factors influencing vulnerability of the above population.
3. Assess the risk associated in terms of client profile of High Risk Groups in the area, Sexually Transmitted Infections burden, condom use pattern and barriers to condom use.

### Steps in Conducting Broad Mapping:

The Broad Mapping shall be carried out for new Districts or Blocks or villages and this has to be followed by site assessment. The Broad Mapping is carried out basically using secondary data and discussion with key informants like health care providers, Integrated Child Development Scheme staff, Integrated Counselling and Testing Centre and Antiretroviral Therapy staff, Panchayati Raj Institution members etc.

The State AIDS Control Societies and Technical Support Unit will constitute a task force represented by State level officers from State AIDS Control Societies, District AIDS Prevention & Control Unit (if present) or District Health Society, civil society. This mechanism is suggested to bring in involvement of multiple stakeholders in decision making especially local representatives.



This task force will come out with a document which clearly informs the State AIDS Control Societies and National AIDS Control Organisation about the possible target areas with significant concentration of at risk and vulnerable population.

Based on the deliberations of this task force, the document highlighting following areas will be worked out:

- (i) Locations or sites with significant at risk and vulnerable population. The villages shall be at least 10 kms or more in plain areas and 5 kms or more in hilly or low population density areas from the nearest town or headquarters. These villages or cluster of four to five villages shall have 15-20 high or medium volume High Risk Groups as reported by nearest Targeted Interventions or other key informants, atleast 200 out migrants with comparatively high HIV positivity (as per nearest Integrated Counselling and Testing Centre or Antiretroviral Therapy data), 5-10 People Living with HIV per 1000 adult population tested as per information from nearest Integrated Counselling and Testing Centre or Antiretroviral Therapy.
- (ii) The task force also can use existing Situation Need Assessment or mapping data for the District but the same shall not be more than two years old.
- (iii) The list of stakeholders or associates which control or influence the mobility of High Risk Groups, their access to condoms, needles and syringes, and other services.
- (iv) The list of potential condom outlets for free and social marketing.
- (v) The list of health care providers who need to be sensitised for syndromic case management and abscess management.
- (vi) The list of locations where information centre can be established.
- (vii) The list of Self Help Groups, Youth Clubs or other institutions which can be tapped for reaching out the communities.
- (viii) Data related to Sexually Transmitted Infections pattern and prevalence among target population and health seeking pattern.
- (ix) Data related to HIV prevalence among High Risk Groups, spouses of High Risk Groups, vulnerable population from nearest Integrated Counselling and Testing Centre or Facility Integrated Counselling and Testing Centre at least for last one year by villages or cluster of villages.
- (x) Data related to current number of People Living with HIV or people on Antiretroviral Therapy from the nearest Antiretroviral Therapy centre by villages or cluster of villages.
- (xi) Data related to migration pattern (seasonality), volume of migration, time of return and who facilitates the migration process.
- (xii) Information related to nearest Targeted Intervention (how many of the High Risk Groups belonging to the rural area are under service), how many of them regularly serviced and how many of them serviced at certain intervals, client profile of these rural High Risk Groups, sites where they solicit (lodge, weekly market, dhabas, market yards, local small industries, quarries etc.)
- (xiii) Information related to Integrated Counselling and Testing Centre referral and access by these rural High Risk Group as documented by the Targeted Interventions – what are the challenges and opportunities.

### **Steps in Conducting Site Assessment in an Existing District:**

The site assessment is carried out by the existing Link Workers Scheme District staff for the following purpose:

#### **Purpose 1:**

To consider only 40% of the villages amongst current number of villages within 10 kms radius from nearest District or Block headquarter (5 kms in hilly or low population density areas) for future Link Workers Scheme implementation. In case of villages closer to adjoining District or Block headquarter



Will be considered as per its original distance from parent District or Block. The Situation Need Assessment data or programme data used for this purpose shall not be more than two years old.

For example, there are 12 villages within 10 kms or 5 kms radius of Block or District headquarters – in future, as per the Guidelines only five villages will continue to have the Cluster Link Workers Scheme based on the site assessment as per following process:

#### Step 1:

Take data of current Link Workers Scheme programme data, Situation Need Assessment data (should not be more than two years), data from People Living with HIV data base, People Living with HIV data from Integrated Counselling and Testing Centre, Antiretroviral Therapy centres, data from Tuberculosis Bacilli programme, data from existing Targeted Interventions in the District about the rural High Risk Groups (how many registered are from villages, how many are getting service from the Targeted Interventions but they reside in villages) etc. Migration data to be collected from Anganwadi Workers, programme data of Link Workers Scheme, any other village level migration data indicating migration to high prevalence Districts) The following format may be used for collecting the data.

District type	Female Sex Workers or Men Who Have Sex with Men per 1000 pop. of the village	Injecting Drug User per 1000 pop. of the village	HIV Positivity among High Risk Groups (ever) in the District	People Living with HIV per 1000 pop. tested in the District (ever and alive)	Migration to high prevalence Districts (% of total pop. In the village)	HIV positivity among migrants (ever) in the District	Whether to be considered for Step 2 if following is fulfilled
	1	2	3	4	5	6	
High prevalence	8 or more	4 or more	1-2%	1-3	>3%	>1-2%	1/2 and/or 3/4 plus 5/6
	6 or more	4 or more	2-3%	2-3	>3%	>1-2%	
	4 or more	4 or more	>3%	3-4	>5%	>2%	
Low prevalence	3 or more	3 or more	1-2% or more	0-1	Pop. Size% of migrants <800 5% or >5% 800-2000 3-5% >2000 2-3% less than 2% would not be considered	>1-2%	1/2 and/or 3/4 plus 5/6
	2-3 or more	2-3 or more	2% or more	0-1	Pop. Size% of migrants <800 5% or >5% 800-2000 3-5% >2000 2-3% less than 2% would not be considered	>1%	
	0-2 or more	0-2 or more	2% or more	0-1	Pop. Size% of migrants <800 5% or >5% 800-2000 3-5% >2000 2-3% less than 2% would not be considered	0.1%	

#### Step 2:

Based on the algorithm given in the previous page the team has to take a decision whether the village is to be continued or not. An excel sheet with formula is available with State AIDS Control Societies and

Technical Support Unit which can be used to enter data and it will automatically calculate the eligibility of the village based on the algorithm.

**The villages which were earlier covered and after site assessment are not considered for Link Workers Scheme may be offered for intensive Information, Education and Communication activities and linkage with nearest Integrated Counselling and Testing Centre for visit by counsellor etc. Instead new villages which are more than 5 or 10 kms radius as applicable having higher risk and vulnerabilities to be selected and Link Workers Scheme may be implemented.**

This is important, most of our programme activities are largely concentrated around the urban or pre-urban areas (towns, headquarters) whereas far off villages are always deprived of services including Information, Education and Communication activities and thus they have heightened risk and vulnerabilities. These far off villages face migration due to poverty and lack of employment opportunities and carry higher risk than villages which are close to economic centre of the Districts where migration happens to grab better opportunities.

**Purpose 2: (to be carried out for each Block where the villages are more than 10 kms from the nearest headquarters (5kms in hilly or low population density areas).**

The purpose of this exercise is to prioritise the villages which will be continued for future interventions. During analysis of performance of villages it has been found some villages although having larger population but lack the risk (no High Risk Group or one to two High Risk Groups only, High Risk Groups which are very low volume and risk, quality of services being very poor during last six months), no People Living with HIV or People Living with AIDS, no migration or migration to nearby town etc.) and vulnerability. Hence, these villages need to be carefully assessed and based on which villages to be prioritised and new villages need to be selected. The same steps to be followed as highlighted in the above sections.

**Village Visit to follow after selection of ineligible villages. At least 10% of the samples of villages to be visited by a team. During the visit following activities is to be carried out.** A village level meeting to be organised. During these meetings specific issues to be discussed related to their experience of accessing services, challenges faced, how many times they have participated in group activities or what can be best method to reach out them in groups.

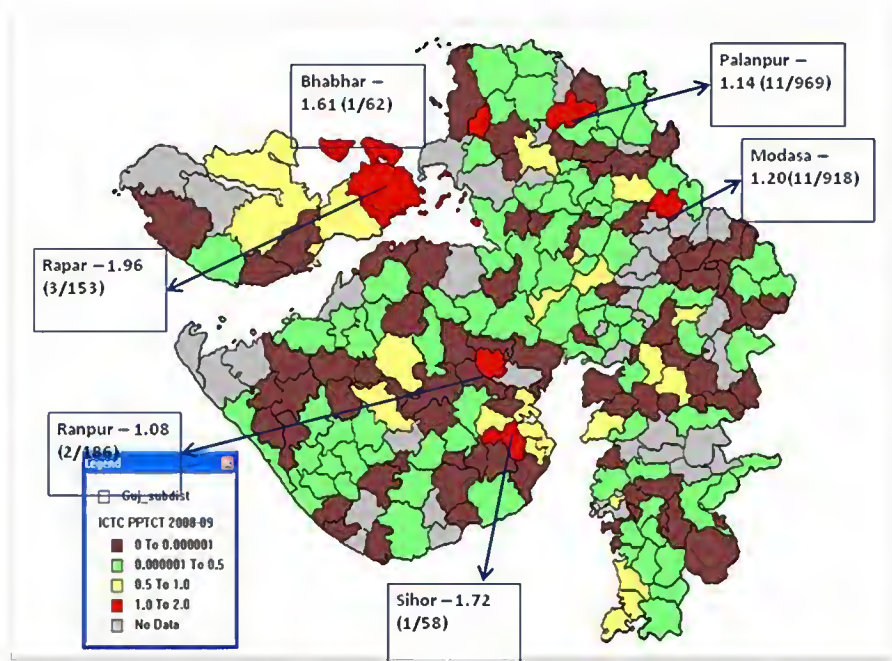
1. The groups will also be meeting the stakeholders in the village like the Panchayat head, Anganwadi Workers, Auxiliary Nurse and Midwifery, Accredited Social Health Activist, Village level workers or Mahatma Gandhi National Employment Guarantee Act staff to understand what support they have been providing for the programme and how this programme can reach more members with their support.
2. At the end of the visits as mentioned above, groups are expected to draw up a social map of the village highlighting the gaps they have found and recommend whether the village need exclusive services of Cluster Link Workers or the support of other stakeholders can have similar results with minimum support of Cluster Link Workers.
3. From these information calculate the broad estimates of target population in a village will be: (the calculation is based on the Situation Need Assessment reports of existing project Districts

not more than two years or programme data in case Situation Need Assessment is more than 2 years)

### Target Setting for Link Workers Scheme Districts:

	Target Group	Existing Districts	New Districts
1	Antenatal Care mothers	100% as per the information from the Antenatal Care register of the village	100% as per the information from the Antenatal Care register of the village
2	Tuberculosis Bacili patients	100% as per the information from the District Tuberculosis Officer or Senior Tuberculosis Laboratory Supervisors of the area	100% as per the information from the District Tuberculosis Officer or Senior Tuberculosis Laboratory Supervisors of the area
3	High Risk Groups (as per definition)	Reported by last Situation Need Assessment (within twoyrs) or programme data (last 6 months)	The target should be fixed within 6 months of implementation in the village (100%)
4	Male population at risk including spouses of Female Sex Workers	5% of adult male population (considering National Sexually Transmitted Infections prevalence of 5% among male)	5% of adult male population (considering National Sexually Transmitted Infections prevalence of 5% among male)
5	Bridge Population low risk but highly vulnerable including spouses of Men who have Sex with Men or Injecting Drug Users	Spouses of migrants or truckers or Injecting Drug Users or Men Who Have Sex with Men and migrants or truckers as per last Situation Need Assessment (within two yrs) or number of households reported in the programme data	Number of migrant or truckers households as informed by Anganwadi workers or Auxiliary Nurse and Midwifery or Panchayat
6	People Living with HIV	Number as reported in the Integrated Counselling and Testing Centre or Antiretroviral Treatment facilities	Number as reported in the Integrated Counselling and Testing Centre or Antiretroviral Treatment facilities
	TOTAL TARGET	Sum of 3,4,5,6	Sum of 3,4,5,6

An example of Broad Map is presented below:



The Broad Map is based on the Integrated Counselling and Testing Centre and Prevention of Parent to Child Transmission data analysed from Computerised Management Information System to prioritise pockets

which require intervention. The next step would be to understand in each Block, which are the Panchayats or cluster of villages which represent higher trends of Integrated Counselling and Testing Centre and Prevention of Parent to Child Transmission positivity as recorded in the nearest Integrated Counselling and Testing Centre.

An example of site map of a village is presented below:





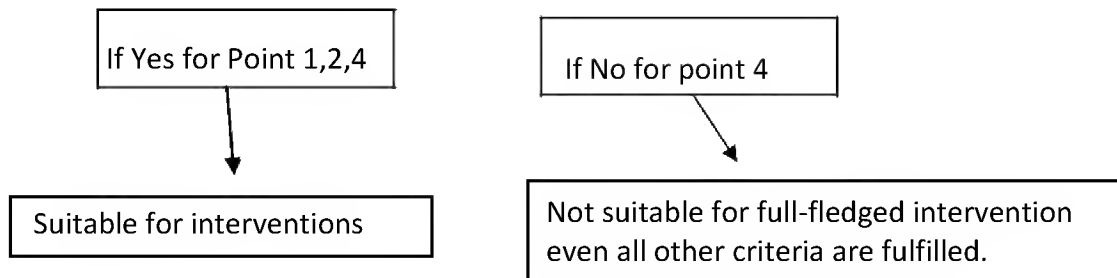
## Steps in Conducting Site Assessment in a New District:

The site assessment is to be carried out by the newly recruited Link Workers Scheme District staff with the support of State AIDS Control Societies and Technical Support Unit for the following purpose:

- To prioritise new villages in compliance with the location and target population as defined earlier.
1. Take the map of District and identify the block with highest rural High Risk Groups as reported by nearest Targeted Interventions line lists or high number of People Living with HIVs as reported by nearest Integrated Counselling and Testing Centre or Antiretroviral Treatment or positive network or Tuberculosis Bacili clinics reporting presence of co-infected patients or high number of Tuberculosis Bacili patients or with high outmigration.
  2. Review of secondary data of nearest Targeted Interventions or hotspots of Targeted Interventions (maximum within 20 kms radius of the village) Female Sex Workers and Male Sex Workers as well as Focus Group Discussion with these groups to understand what percentage of High Risk Groups are from the village and what barriers to condom use are.
  3. Review of secondary data of Anti-retroviral clinics and HIV testing centres in the nearby areas to understand what percentage of on Antiretroviral Treatment or pre-Antiretroviral Treatment clients belong to the villages.
  4. Review of secondary data of Sexually Transmitted Infections clinics and health care providers in the nearby areas to understand what percentage of clients, High Risk Groups belong to the villages and are having Sexually Transmitted Infections and health seeking behaviour.
  5. Collect information regarding potential outlets for condom social marketing, any kind of health facilities catering to general population.
  6. Collect information regarding the existence of sex networks (both male and Female Sex Workers) and the support structures for these networks, operational timings of Key Populations in the area, the concentration of High Risk Groups.

**Based on these information the Management and Technical Team will decide and inform about the suitability of the village for designing an intervention. While making such decision following algorithm may be used:**

1. 60% of the Female Sex Workers are medium (more than six clients in last 15 days) volume Female Sex Workers and there is at least three Sexually Transmitted Infections or Reproductive Tract Infections reported for 40% of the Female Sex Workers for two quarters.
2. 50% of Men Who Have Sex with Men, Male Sex Workers, clients of Female Sex Workers or spouses of Men Who Have Sex with Men or Injecting Drug Users have reported at least one infection of Sexually Transmitted Infections during two quarters.
3. Injecting Drug Users with four to five injecting episodes per week.
4. 60% of those are who are migrants or truckers are coming back to village at least more than two times a year and there is significant information about Sexually Transmitted Infections.
5. At least 5-10 per general population tested are People Living with HIV or are on Antiretroviral Treatment.



## 2.2 Determining Availability of Appropriate Services

Availability of appropriate services at any location which has suitability for intervention will depend upon following:

1. The quality of engagement with target population.
2. The efficiency of coverage of target population with services.

This is important from the point of placing Link Workers Scheme in a village or cluster of villages:

- (i) Efficiency of coverage: In order to optimise the utilisation of resources, it is necessary that these services are accessed. This will essentially depend upon the availability of services such as syndromic management, HIV testing and counselling services.
- (ii) Quality of engagement: From an intervention perspective, it is also important that the point of access provides an environment where the target population continue to access service with confidentiality and these services are stigma free in depth with the programme.

It is not expected that services available far off (more than 10-20 kms) will be accessible for High Risk Groups and vulnerable population in rural settings considering issues with affordable transportation. Hence, it is important to understand different locations and its importance in designing services.

### Different options for service delivery in rural settings:

- In case the existing government facilities have provision of syndromic case management and or HIV testing and counselling within 10 kms (5kms in hilly or low population density areas) from the villages or cluster of villages the same may be considered for referrals. In such cases the target for those villages will be significantly higher considering availability of services may be of 80%.
- The proposed health camps with syndromic case management and or HIV testing and counselling services can be tagged with the villages or cluster of villages and at least 60% of the High Risk Groups shall receive services at least once a year.
- The provision of mobile health clinics with syndromic case management shall be utilised to provide services under National Health Mission.
- The provision of mobile Integrated Counselling and Testing Centre vans along with other activities may be planned to provide HIV testing and counselling services at least twice a year and shall ensure 80% of the High Risk Groups are tested.



### 2.2.1 Types of Villages or Cluster of Villages

They can generally be classified under three types.

#### 2.2.1.1 Villages or Cluster of villages primarily of High Risk Groups

These are villages with

- (i) more than 10 High Risk Groups mostly of medium volume (more than 6 clients in 15 days) or most of them are young and new.
- (ii) with less than 10 High Risk Groups but are of high volume (more than 8 clients in last 15 days)
- (iii) high degree of mobility (atleast more than three days a week) Female Sex Workers or Men Who Have Sex with Men or Injecting Drug Users move to the nearest highway, dhabas, market yard, railway station, construction sites, Targeted Interventions area etc. and solicit clients.
- (iv) Targeted Interventions line list highlights significant number of Female Sex Workers, Men Who Have Sex with Men or Male Sex Workers or Injecting Drug Users belong to the village or its peripheral hamlets or cluster of villages.

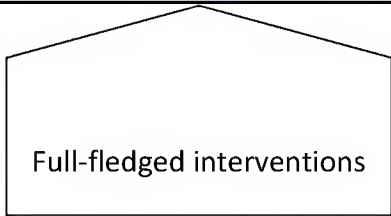
#### 2.2.1.2 Villages pre-dominantly out migration villages with more than 20% of the adult males migrate more than three months in a year.

- (i) Households with more than 20% adult male out migration and significant of them are on Antiretroviral Treatment or are on pre-Antiretroviral Treatment.

#### 2.2.1.3 Villages have low risk and vulnerable populations but have significant number of persons are from People Living with HIV community

- (i) These villages are important from the point of halting the transmission by introducing timely treatment and ensuring adherence.

**Hence, based on these considerations the design of interventions and services can be determined. The same is presented below:**

Villages or Cluster of villages primarily of High Risk Groups	
Villages pre-dominantly out migration villages	
Villages have low risk and vulnerable populations but have significant number of persons are from People Living with HIV community	

## 2.3 CAPACITY BUILDING OF IMPLEMENTING PARTNERS

The role of State AIDS Control Societies and Technical Support Unit is important from the point of bringing common understanding among different stakeholders about the expected outcomes of the interventions, the implementation approaches and expected impact.

While the in-house training may be imparted through the project staff so that they can be used for training of new staff as well as can support the project ongoing basis.

The training activities will be carried out by State Training and Resource Centres in States with State Training and Resource Centres, in rest of the States the State AIDS Control Societies would use trained resource persons to deliver the training for Link Workers Schemes. Therefore, it is important

that the capacity of the implementing partners is built in and a system of local evidence building and feedback to the programme is built in within the prevention intervention.

The capacity building inputs should include:

- (i) Training (induction, refresher, specialised theme based training)
- (ii) “Hand holding” or mentoring

Various themes for Capacity Building can be:

Areas	Participants
<ul style="list-style-type: none"> <li>(i) National AIDS and Sexually Transmitted Diseases Control Programme</li> <li>Basic information on HIV and Sexually Transmitted Infections</li> <li>(ii) Behaviour Change Communication and development of Information, Education and Communication materials</li> <li>(iii) Dealing with myths and misconceptions</li> <li>(iv) Peer education and community outreach</li> <li>(v) Harm Reduction including Opioid Substitution Therapy</li> <li>(vi) Condom programming</li> <li>(vii) Safer sex negotiation</li> <li>(viii) Sex and sexuality</li> <li>(ix) HIV testing and counselling</li> <li>(x) Outreach planning, monitoring</li> </ul>	<ul style="list-style-type: none"> <li>Cluster Link Workers</li> <li>Supervisors</li> </ul>
<ul style="list-style-type: none"> <li>(i) Stigma and discrimination</li> <li>(ii) Community participation and empowerment</li> <li>(iii) Sexually Transmitted Infections management</li> <li>(iv) Advocacy</li> </ul>	<ul style="list-style-type: none"> <li>Supervisor</li> <li>District Resource Person</li> </ul>
<ul style="list-style-type: none"> <li>(i) Reporting systems</li> <li>(ii) Project management</li> <li>(iii) Resource mobilisation</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and Evaluation cum Accounts Assistant</li> <li>District Resource Person</li> </ul>

The “Handholding” or “Mentoring” visits carried out by the State AIDS Control Societies and Technical Support Unit teams or by external experts need to be outlined keeping in mind that the project staff are able to understand the gaps and are able to find solution within their own settings. The objectives of these visits shall be:

1. Brainstorming and facilitating to identify gaps, opportunities
2. Facilitating in finding out solutions
3. Facilitating advocacy and networking
4. Bringing in scale for services with private sector, other referral services for Tuberculosis Bacili, Antiretroviral Treatment services
5. Monitoring of the performance benchmarks and grading the performance
6. Capacity building through onsite support

## 2.4 MONITORING AND EVALUATION

The implementation for Link Workers Scheme will be monitored by the State AIDS Control Societies and Technical Support Unit teams using specific supervisory tools.

The basic purpose of the monitoring is to ensure:

1. That the intervention is aligned with the National Guidelines or aligned to the strategies worked out in the proposal in line of the National Guidelines.
2. That the interventions has put systems for peer education by Cluster Link Workers (recruitment as per the Guidelines), updated outreach plan, appropriate service delivery system, networking and advocacy approaches, social marketing of condom programme, linking with HIV testing facilities and linking with Antiretroviral Treatment facilities.
3. That the intervention has been reporting on National Guidelines.
4. That the intervention has been making efforts to engage with different stakeholders towards addressing programme management issues, stigma and discrimination as well as overall improvement of performance of the intervention.
5. Triangulation of data on Sexually Transmitted Infections incidence among High Risk Groups with other sub-groups and Key Population groups in the area to understand the transmission dynamics and provide necessary inputs.

In addition to the routine monitoring there is need for monitoring of specific outcomes such as; condom use pattern among different clients and vulnerable population, behaviour change patterns among these groups, HIV testing and Antiretroviral Treatment compliance rates among High Risk Groups and other vulnerable populations.

These are important from the point of improving the outcomes of the intervention. While monitoring of these interventions are important from the point of investments, the process of evaluation is required to understand the systems in place and their effectiveness and efficiency, effectiveness of existing referral systems and delivery pattern.

The role of State AIDS Control Societies and Technical Support Unit teams in Evaluation would be:

1. Build capacity of the team, experts to implement evaluation tools.
2. Facilitate the process of evaluation. Provide critical feedback to the policy makers, stakeholders and implementers in improving the quality of interventions.
3. Build in and manage the quality assurance and quality improve mechanisms within the project.
4. Carry out documentation of best practices, training needs and outcome assessments using various tools.

### Specific Strategy for North Eastern States and Tribal areas:

While the implementation mechanism of Link Workers Scheme will be same for North Eastern States and Tribal areas in terms of target population, services for each target population and performance indicators. While the service delivery mechanism will be more based on reach out models such as health camps linked with Testing services, outreach models for needle or syringe distribution, linkage with Opioid Substitution Therapy centres will be high priority in Districts with Injecting Drug User programme requirements.

Similarly, the management model of implementing Link Workers Scheme in North East States and tribal areas will include merger of neighbouring districts with less than 60 targeted villages in each District to optimize the management by one Non-Governmental Organisation. The villages are to be selected as per the Guidelines and Districts may be merged as one cluster to implement the scheme. The proposal has to be prepared by State AIDS Control Societies and the same will require prior approval of National AIDS Control Organisation.

#### Take home messages:

- (i) The role of State AIDS Control Societies and Technical Support Unit team is to support the programme in building evidence for planning, better implementation and building capacity of the partners.
- (ii) Broad Mapping, site assessments are key steps in estimating the denominator and assessing the feasibility.
- (iii) Villages or cluster of villages with 60% of the Female Sex Workers are medium (more than four clients per week) volume Female Sex Workers and there is at least three Sexually Transmitted Infections or Reproductive Tract Infections reported for 40% of the Female Sex Workers for two quarters AND/OR 50% of Men Who Have Sex with Men, Male Sex Workers, clients of Female Sex Workers or spouses of Men Who Have Sex with Men or Injecting Drug Users have reported at least one infection of Sexually Transmitted Infections during two quarters AND/OR 60% of those are who are migrants or truckers are coming back to village at least more than two times a year and there is significant information about Sexually Transmitted Infections in addition to at least 10 per adult population tested are People Living with HIV or are on Antiretroviral Treatment.
- (iv) Injecting Drug Users with five to six injecting episodes per week to be considered for intervention
- (v) Capacity building of partners and continuous monitoring are essential to maintain quality and ensure optimal investments.

## CHAPTER 3: Guidelines for Implementing Partners

In this chapter, following areas are covered:

1. What are principles of service delivery among risky and vulnerable population in rural settings
2. Programme Strategies
3. Different service delivery models
4. Component of service delivery
  - a) Behavioural Component – how to prepare micro plan for outreach, what are the outreach components, what are the components of Interpersonal Communication and Behaviour Change Communication
  - b) Biomedical Component – what are the different services, how to link with services
  - c) Structural Component
5. Programme Management
6. Human Resource Management

### 3.1 Principles of Service Delivery Among Risky and Vulnerable Population in a Rural Setting

Considering the nature of target population and the socio-cultural milieu it is important that the service delivery among these populations need to be guided by certain basic principles:

#### 1. Alignment with National Guidelines

The intervention is required to align with all existing National Guidelines for its various components.

#### 2. Differential Approaches

Different approaches are required for rural High Risk Groups based on the dynamics of the sexual and social networks of each of the sub-category (from where they operate, who controls these networks etc.). The vulnerability pattern (outmigration volume and mobility pattern), sexual behaviour of spouses of High Risk Groups, availability of Sexually Transmitted Infections services and condoms will determine the approaches.

#### 3. Community participation and ownership building

Ideally, the social and sexual network in rural settings is homogenous in nature and building affinity for mobilising them as community for risk or vulnerability reduction is achievable. Their participation needs to be structured based on their perceived needs may be in the form of mobilising through Self Help Groups, Small groups based on their profession or occupation etc.

#### 4. Adoption of combination prevention approaches

Considering the different scenario in which the interventions will be designed it is important that combination prevention approaches may be adopted targeting both High Risk Groups and their regular sexual partners both for prevention and treatment. However, these approaches are to be confidential and stigma free.

#### 5. Affordability, Acceptability and Accessibility of services

Considering the low literacy level, varying degree of health seeking behaviour owing largely due to limited access and prevailing myth, the services may be accessible, acceptable and affordable.

#### 6. Confidentiality and Continuum of services

Rural High Risk Groups and vulnerable clients prefer to be anonymous about their identity as well as behaviour, hence it is important to ensure confidentiality of services offered. Similarly it is important to ensure mechanisms for continuity of services across their mobility especially if the High Risk Groups can be linked to nearest Targeted Interventions to ensure a full package of services.

### 3.2 Programme Strategies

**Link Workers Scheme is a prevention intervention programme targeting rural risky and vulnerable population. From epidemic response perspective, the scheme is expected to target both vertical transmission and lateral transmission of HIV among these target population.** The following diagram describes the importance of these transmission dynamics and programme strategies of Link Workers Scheme:



Routes of Transmission	Vertical Transmission	Lateral Transmission	Transmission from Positive clients
At risk communities	Pregnant Mother	Sexually active men and women (High Risk Groups and their clients) Migrants and their spouses	Spouses of positive clients and their sexual partners, children
Risk level	Very High	Moderate to High	Highest
Visibility in the community	High	Low	Low
Strategy	Outreach combined with service linkage with existing Accredited Social Health Activist and Auxiliary Nurse and Midwifery	Outreach combined with Behaviour Change Communication, Enabling Environment Component strong linkage to services	Outreach combined with strong linkage to services and positive prevention components

High visibility High Risk Population		Low visibility High Risk Population		High visibility Moderate Risk Population
(i) Ante Natal Care Mothers	(i) Spouses of migrants	(i) Female Sex Workers	(i) Clients of High Risk Groups	(i) Youth
(ii) High Risk Groups with Tuberculosis Bacili	(ii) Injecting Drug Users and their partners	(ii) Men Who Have Sex with Men	(ii) Spouses of High Risk Groups	(ii) Mobile population
(iii) Tuberculosis Bacili patients	(iii) Migrants	(iii) Transgender or Hijra		
(iv) People Living with HIVs or People Living with AIDS		(iv) Male Sex Workers		

Step 1. COVERAGE TO BUILD RAPPORT Step 3. IDENTIFY HIGH RISK GROUPS, COVERAGE AND SERVICES

Step 2. RAPPORT BUILDING FOR HIGH RISK GROUPS Step 4. REFERRALS

The above framework shows that the Cluster Link Workers shall start covering High visibility High Risk Populations to link them with services provided by other workers in the area. This will help them to build rapport in the community and will help them to identify High Risk Groups and other Low visible High Risk Population. Once these group of high risk population is identified, snow balling need to happen to identify other members in the same village or in the area. Cluster Link Workers are expected to link all these members with services, follow up them and ensure adherence and continuity. Whereas the moderate risk groups need to be sensitised and provided opportunity to access information centre and health camp services.

This guideline outline broad strategies under three components as described above:



**Behavioural Component:**

- 1) **Outreach:** Designed specific to the nature of target population  
Location, time specific micro- plans to conduct outreach will be designed (details of micro-plan available in Training Module)  
  
Peer driven approach (Self Help Group members, Direct Observed Treatment and Short Term Chemotherapy providers etc.)
- 2) **Communication:** Both Interpersonal Communication (one to one) and group level approaches Carried out by Cluster Link Workers and volunteers  
Targeting risk perception, condom use, safer injecting practices, Opioid Substitution Therapy, service uptake, self worth
- 3) **Condom Promotion:** Primarily through social marketing Condom demo and free condom availability will be restricted to those who are medium and high risk Female Sex Workers, Men Who Have Sex with Men, Injecting Drug Users, and Male Sex Workers.  
Free condoms for other target population need to be linked with nearest Accredited Social Health Activist and Auxiliary Nurse and Midwifery.
- 4) Provision and collection of needles and syringes by linking to nearest Targeted Interventions (distribution by Cluster Link Workers based on the requirements of the Injecting Drug Users preferably collected from Targeted Interventions on monthly basis)

**Biological Component:**

- 5) **Services:** Clinical services for treatment of Sexually Transmitted Infections or Reproductive Tract Infections, abscess by linking to nearest health facilities, camps organised in the area.  
Linked to HIV counselling and testing  
  
Referral and networking with other service providers
- 6) HIV testing and counselling: Primarily linked to Integrated Counselling and Testing Centre or Facility Integrated Counselling and Testing Centre or Integrated Counselling and Testing Centre vans, Health camps

**Structural Component:**

- 7) **Community Systems Strengthening:** Using village health and sanitation committee and District AIDS Coordination Committee as platform for sharing the progress and issues that needs to be addressed with support of District and Block level functionaries.
- 8) **Creation of Enabling Environment:** Cluster Link Workers are expected to work with other health staff (Auxiliary Nurse and Midwifery, Accredited Social Health Activist), Anganwadi Workers to ensure that the target population are able to access information, services in a stigma free environment. Especially the village mothers meeting shall be used to reach out to the females and their family members regarding myth and misconceptions on HIV or AIDS and ways to prevent.

**Different Service Delivery Models**

In summary, the different service delivery models that may be feasible for implementation in the locations which have been found feasible for Link Workers Scheme are as follows:

Type of location	Type of service component	Service delivery model
Villages predominantly Concentrated with rural High Risk Groups or out migration villages (as defined earlier) within 10 kms or 5 kms in hilly or low population density areas (not less than 10 kms) from the nearest Govt. facility in Integrated Counselling and Testing Centre or Facility Integrated counselling & Testing Centre	Behavioural Component	Mid-media linked with State AIDS Control Societies campaign Condom outlets Counselling by Cluster Link-Workers
	Treatment of Sexually Transmitted Infections or Reproductive Tract Infections, Abscess management in Injecting Drug Users	Linked to nearest Primary Health Centre or Community Health Centre or trained private providers
	Provision of Opioid Substitution Therapy	Linkage with nearest Opioid Substitution Therapy Centre
	HIV Counselling and testing	Linkage with Integrated Counselling and Testing Centre or Facility Integrated Counselling & Testing Centre
Villages predominantly concentrated with rural High Risk Groups or outmigration villages (as defined earlier) more than 10 kms or 5 kms in hilly or low population density areas from the nearest Govt. facility in Integrated Counselling and Testing Centre or Facility Integrated counselling & Testing Centre	Behavioural Component	Mid-media linked with State AIDS Control Societies Campaign Condom outlets Counselling by Cluster Link Workers
	Provision of Opioid Substitution Therapy	Linkage with nearest Opioid Substitution Therapy Centre
	Treatment of Sexually Transmitted Infection or Reproductive Tract Infections, Abscess management in Injecting Drug Users	Linked to nearest sub centre Through Primary Health Centre or Community Health Centre or trained private providers
	HIV Counselling and testing	Linkage with Mobile Integrated Counselling and Testing Centre or Mobile Medical Unit with testing facility Linkageduring health camps planned by State AIDS Control Societies or Link Worker Scheme with testing facility
Type of location	Type of service component	Service delivery model
Villages significant concentration of People Living with HIV or People Living with AIDS and other risk-groups (as defined earlier) within 10 kms or 5 kms in hilly or low population density areas from the nearest Govt.	Behavioural Component	Linkages with nearest People Living with HIV network Linkages with other social welfare Schemes through Panchayat or Taluka office Condom outlets Counselling by Cluster Link Workers
	Antiretroviral provisioning	Linked to nearest Link Anti Retro Viral Treatment or Anti Retro Viral Treatment centres

facility in Integrated Counselling and Testing Centre or Facility Integrated Counselling & Testing Centre	HIV Counselling and testing	Linkage with Integrated Counselling and Testing Centre or Facility Integrated Counselling & Testing Centre
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### 3.3 Components of Service Delivery

The services under these interventions are primarily considered three components, they are:

1. Behavioural Component
2. Bio-medical Component
3. Structural Component

#### Behavioural Component

In Link Workers Scheme, the behavioural component of the programme is implemented in principle of location time cluster approach to maximise the inputs provided. Considering the low visibility and anonymous nature of the population, the location time cluster approach is used to reach out the High Risk Groups or their partners (regular or commercial) through one to one (by home visits), one to group session (through Self Help Group meetings, mothers meeting, youth group meetings, gram sabha meetings) and mid-media activities. To delivery communication session the Cluster Link Worker has to prepare a micro-plan.

The behavioural component essentially a mix of services which enables the client to perceive the risk associated with certain behaviour and enables with services, condoms, needles and syringes to practice safer behaviour and thus reducing the risk associated.

Accordingly the framework of implementing and monitoring of this component will be as follows:

What	How	Responsibility	Expected outcome	Measurable indicators
Health education	Through Inter Personal Communication, Mid-media and Counselling	Cluster Link Workers and Supervisor	Increase in condom use, safer injecting practices, Opioid Substitution Therapy, and reduction in Sexually Transmitted Infections burden	(i) Increase in condom use in last sex (ii) Decline in Sexually Transmitted Infections burden among High Risk Groups and their clients (iii) Increase in Opioid Substitution Therapy registration (iv) Increase in using clean needles and syringes in every injecting episode
Increase in risk perception	Through Inter Personal Communication, Counselling	Cluster Link Workers	Increase walk-in clients to the Integrated Counselling and Testing Centre or Facility Integrated counselling & Testing Centre or Integrated Counselling and Testing Centre van for counselling and testing	(i) Increase in walk-in clients versus referral clients

### 3.3.1 Preparation of Micro plan by Cluster Link Workers

The following steps are required to be undertaken.

#### 3.3.1.1 Preparation of Site Map

##### Step 1: Preparation of Site Map:

Preparation of Site Map of the village or cluster of villages is required to prepare the micro-plan. A site map provides geographical and social overview of an area, including details regarding landmarks. It will help in planning to decide how many sessions required, who are to be targeted and where the services are to be linked.

This also provides to collect detailed information in a phased manner, starting with high visibility high risk population to low visibility high risk population and ensure their linkage with services. (as mentioned at the start of this chapter).

Site Mapping will focus on the following

- (i) List out all households with high visible high risk populations and their current service uptake status especially related to accessing services for treatment of Sexually Transmitted Infections or Reproductive Tract Infections, HIV counselling and testing.
- (ii) Prioritise the households with migrants, People Living with HIV or People Living with AIDS and Tuberculosis Bacili patients.
- (iii) Differentiate by volume and risk level of High Risk Groups and injecting frequency of Injecting Drug Users

#### ACTIVITIES TO BE TAKEN UP BEFORE SITE MAPPING

- (i) Introduce yourself to the Taluka Medical Officer preferably with zonal supervisor during weekly meeting of Auxiliary Nurse and Midwifery and Accredited Social Health Activist. Briefly describe the Link Worker Scheme and expected support from Health Society and National Health Mission. (especially supports in terms of requirements for free condoms, participation in special activities, linkage of pregnant mothers to HIV testing, linkage of High Risk Groups to Sexually Transmitted Infections treatment and HIV testing, support for conducting health camps, linkage for HIV Tuberculosis Bacili programmes).
- (ii) Cluster Link Workers shall attend similar meeting at least once in three months preferably the zonal supervisor shall present in these meetings to discuss progress and issues that needs to be addressed by Taluka or Block level officers of various departments.

#### **Steps in Site mapping (is a continuous process at least to be done every 3 months)**

- (i) Start by asking general questions about the village. Spread chart paper on the ground, hand over the sketch pens, and request the participants to draw the geographical outline of the village and its adjoining 5 kms area. Participants can be youth groups, mothers.
- (ii) Request participants to mark the important landmarks. Whilst marking landmarks probe for land marks such as sub-centres, house of Accredited Social Health Activist, Anganwadi centres, doctors or medical facilities, existing and potential condom outlets, Key Population hotspots, congregation points of local migrants and truckers.
- (iii) Next, ask participants to mark the specific households with pregnant mothers (guide with your list), migrant families, Tuberculosis Bacili patients.

- (iv) Whilst the participants draw the map, ask them probing questions to generate information on mobility of village population (both male and female), purpose of mobility and mark those households. Note down all the information collected in the map
- (v) Additionally, after the exercise discuss this map and information with Auxiliary Nurse and Midwifery, Accredited Social Health Activist and mark households with People Living with HIV or People Living with AIDS, High Risk Groups (already known).

(iii) Collect the list of pregnant mothers on three monthly basis from the Auxiliary Nurse and Midwifery The Broad Mapping is to be carried out at least for five different parts in a village with more than 500 households and consolidate into one map. In case of less than 500 households the map is to be carried out in three different parts and in less than 200 households one map is to be prepared.

## Step 2: Line listing of beneficiaries:

The following table shows the process and source of information for line listing:

Type of Population	Population	Source of information	When to collect and update
High visibility High Risk Population	Ante Natal Care Mothers	Auxiliary Nurse and Midwifery or Accredited Social Health Activist register	Every quarter
	High Risk Groups with Tuberculosis Bacili	Auxiliary Nurse and Midwifery	Every month
	Tuberculosis Bacili patients	Auxiliary Nurse and Midwifery or Direct Observed Treatment and Short Term Chemotherapy provider	Every month
	People Living with HIVs or People Living with AIDS	Antiretroviral Treatment or Nearest link Antiretroviral Treatment or Integrated Counselling and Testing Centre or Positive Network	Every 3 months
	Spouses of migrants	Migrant households information through discussion and home visits	During home visits
	Migrants		During home visits
	Injecting Drug Users and their partners	Auxiliary Nurse and Midwifery or Accredited Social Health Activist or during home visits	During home visits
	Female Sex Workers	(i) From line list of existing Link Worker	Every month

Low visibility High Risk Population	Men Who Have Sex with Men	Scheme data or Targeted Interventions data (ii) During home visits	Every month
	Male Sex Workers		Every month
	Injecting Drug Users		Every month
	Transgender or Hijras		Every 3 month
	Clients of High Risk Groups	Through discussion and home visits	During home visits
	Spouses of High Risk Groups		During home visits

A simple format for line listing is annexed at Annexure1 and 2. The objective of maintaining a line list is

- To identify households by risk category, update their service requirements and service accessed.
- To monitor the progress of Cluster Link Workers scheme by villages and cluster of villages.
- To understand workload for a village or cluster of villages and help in optimising the requirements of Cluster Link Workers in a District irrespective of work load.
- To minimise duplication of services for High Risk Groups who are also line listed in a nearby village or nearby Targeted Interventions.
- Helps in building rapport and ensuring adherence of services.

### Step 3: Risk and Vulnerability Mapping

**Social and Sexual Networks mapping:** Identify the social networks and sexual networks especially in case of Female Sex Workers, Men Who Have Sex with Men, Male Sex Workers, Transgender or Hijras, Migrants, Spouses of migrants to understand the service requirements, factors which influence their health seeking behaviour.

**Understanding the risk exposure and risk pattern:** Amongst the listed High Risk Groups, **initially provide condoms or needles or syringes without accurately estimating the requirements. While doing so over a period**, the Cluster Link Worker will be able to estimate the risk pattern (number of clients per week) and risk exposure (whether regular or commercial clients). Then these information may be used to calculate condom requirements per week and how the condoms can be supplied.

**COMPLETE THE SITE MAP by including the above information on a map i.e. households map, social and sexual network map and line listing.**

Example of information from site maps consolidated at Block level:

Name of the Block	Name of the village	Total number of households	Number of segment Maps prepared	Total number of households with different categories	Total number of target population	Source of information



### 3.3.1.2 RESOURCE MAPPING

In order for the Cluster Link Workers to be able to link the target population to services, they first need to understand the exact location and services already available which can be linked or to be planned. This process is called resource mapping.

Steps to make a resource map:

1. Using the information collected regarding sub-centres, Accredited Social Health Activist, Anganwadi centres, doctors or medical facilities, existing and potential condom outlets during preparation of site map as a template, the Cluster Link Workers shall mark out all the service centres in the project area.
2. These centres shall also include HIV related service and include Sexually Transmitted Infections clinics, HIV counselling and testing centres, Antiretroviral facilities, Tuberculosis Bacilli sputum microscopy centres, Malaria blood testing facilities etc.
3. Collect information of timings of services, contact details of these services and sensitise them about the scheme.

These services may be individual providers, government facilities or existing wellness centres.

This resource map helps in planning various services under the project.

### 3.3.1.3 Preparation of outreach plan

#### Why we prepare the outreach plan?

- (i) The outreach plan is prepared to reach out to target population based on the timings, availability at any site within the villages or cluster of villages.
- (ii) The outreach plan is prepared to focus on sites which require additional efforts to provide services.
- (iii) The outreach plan helps in planning mid-media activities by State AIDS Control Societies, condom depots, advocacy activities based on the issues in each site.

#### Who would prepare the outreach plan?

- (i) The plan preferably is prepared by the supervisor with support of Cluster Link Workers and data of previous services offered in the area.
- (ii) Collect information from the stakeholders during the stakeholder meetings besides through discussion with target population at each site.

#### How often the outreach plan would be prepared?

- (i) The outreach plan preferably is prepared once in 3 months. This ensures stability in the programme. Frequent change unless required may affect the services and outputs.

#### When outreach should happen?

- (i) The outreach shall be conducted at the convenience of the target population especially when they are in a mental state to listen and interact. In case we plan our outreach when they are busy with household work, in a public place etc. they may not prefer to be interfered.
- (ii) Hence, preferably the outreach be conducted during the time when a group of target population is available for discussion or some activities.

- (iii) Unless prescribed by State or National AIDS Control Organisation team the outreach timings may adhere to the above norms.
- (iv) Such outreach timings may have impact on the office timings of the agency. However working time of Cluster Link Workers preferably match with the outreach timings of the villages or cluster of villages.

#### Where the outreach sessions to be conducted?

- (i) The outreach session (one to one) can be conducted in the house or agreed place.
- (ii) Preferably shall be one to group in the information centre, during group meetings, Self Help Group meetings, mothers meetings, near the worksite or weekly market, in the Auxiliary Nurse and Midwifery or Anganwadi centre or any other preferred place.

#### How often the outreach sessions to be conducted?

Based on the risk pattern and service requirements the frequency of outreach sessions need to be planned. Following table is suggestive to carry out number of sessions:

Settings	Population	Number of sessions per month	Number of follow up in a month
1 to 2 villages with at least 50 to 52 target population per month excluding migrants, youth, clients or spouses of High Risk Groups, mobile population	Ante Natal Care Mothers	Once till the mother gets tested If positive once a month till delivery Once a month if the baby is positive	During breast feeding period, once a month
	High Risk Groups with Tuberculosis Bacili	Once till the person is tested for HIV If positive, to be motivated for CD4testing and Antiretroviral Treatment accordingly	Every month
	Tuberculosis Bacili patients		Every month
	People Living with HIVs or People Living with AIDS	On Antiretroviral Treatment or Loss to Follow up or Missed cases once a month in coordination with CSC team in the area if available	Every 3 months
	Spouses of migrants	Twice a month during home visits or return season of migrants	During home visits
	Migrants		During home visits
	Injecting Drug Users and their partners	Every alternate day in case the Injecting Drug Users have high injecting frequency (4-5 times per week) In other cases, twice a month for providing Needles or Syringes	During home visits
	Female Sex Workers	Weekly at least once for providing condoms and referral for testing	Every month
	Men Who Have Sex with Men		Every month
	Male Sex Workers		Every month
	Transgender or Hijras		Every 3 months

In case there is a cluster of villages to be serviced by the Cluster Link Workers, then the weekly services are to be converted to fortnightly once, but it shall be ensured that all line listed target population is reached at least once in a month.

In case the High Risk Groups are not staying in the Link Workers Scheme village but they operate from the village (Female Sex Workers work from the village, Injecting Drug User visits for injecting

or picking up drugs, Men Who Have Sex with Men visits for high risk activities) they need to be targeted during their availability in the village for service delivery and follow up. For follow up also the concerned Accredited Social Health Activist, Auxiliary Nurse and Midwifery may be sensitised to provide condoms in their village from where the High Risk Groups belongs to, however they shall not disclose the identity of the High Risk Groups.

#### What are the components of outreach session:

- (I) Information sharing about the risks associated with each target population and ways to prevent.
- (II) Condom Demo by the staff and Re demo by the High Risk Groups, migrants or mobile population
- (III) Sharing of information related to the HIV Testing and counselling, Antiretroviral, Condom Depots
- (IV) Information collection from the group about the services they are accessing, any issue faced related to availability or accessibility.
- (V) Information about preferred providers or locations where condoms can be made available.

#### How the outreach plan is prepared:

Suppose the site map of three different sites indicate following information, then how the outreach plan would be prepared:

Places		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Household no. 12,14,16,2 9,38	No. of target pop.	0	6	8	0	6	0	0
	Timings		2-3 pm	3-4 pm		2-3 pm		
Mothers meeting in Auxiliary Nurse and Midwifery centre	No. of target pop.			15 including 6 of the above				
	Timings			10-11 am				
Market day	No. of target pop.		18 including 3 of the Above					
	Timings		12 to 3pm					

Based on above information it is very clear that:

**Monday: 2-3 pm – outreach need to be planned by home visits (one to one session)**

**Tuesday: 10-11 am outreach need to be planned at Auxiliary Nurse and Midwifery centre (one to group session)**

Similar plans can be worked out for other days looking at the timings and convenience of target population.

#### 3.3.2 Behaviour Change Communication

The communication strategy will have the following approaches:

- (i) **Dialogue-based one to one or one to group Interpersonal Communication:** Peer-led Interpersonal Communication is critical to enhance the credibility of messaging in the field. The messaging shall be dialogue-based as opposed to top-down flipbook style messaging. Dialogue-based communication promotes critical thinking and self-reflection by the participants. These are necessary steps towards behaviour change. Some of these tools are discussed at Annexure-3
- (ii) **Creative, synchronised and thematic skits and role plays:** Given the large numbers of youth available in the village, they can play significant role in disseminating message on stigma and discrimination related to HIV or AIDS. It is necessary to supplement Interpersonal Communication activities with street plays, exhibitions, games etc. These serve to widen the exposure base of the programme, increase awareness of services and generate demand.  
  
**Synchronising these activities with other events at Panchayat Level through State AIDS Control Societies helps reinforce key messages and build sustained engagement with the target population.**
- (iii) **Selective mass media:** Mass media, particularly outdoor signage, radio programmes in local language provide a mechanism to promote programme services and expand awareness on a large scale. Mass media alone is unlikely to change behaviour, but it can plant the seed of a demand for services and a desire to learn more about HIV. These are expected to be worked out by State AIDS Control Societies only.

### 3.3.2.1 Peer-led dialogue-based Interpersonal Communication

Dialogue based Interpersonal Communication uses tools and methods that stimulate a discussion on an issue and enable the group to problem-solve and arrive at an agreed course of action. Peer-led Interpersonal Communication uses members of the population (amongst the mothers, amongst the High Risk Groups, amongst the youth) as facilitators to manage the discussion.

**All the Interpersonal Communication sessions with the High Risk Groups shall preferably be one to one and the tools used in these sessions are to be kept with the office of Link Workers Scheme for verification by State AIDS Control Societies or Technical Support Unit. The Cluster Link Workers are expected to use various tools for discussion with the High Risk Groups, they shall indicate the village, date and the signature of the High Risk Groups with whom the tool is used. These tools after signature shall be handed over to the Block supervisor and the same need to be kept in the office of Link Workers Scheme for verification.**

The advantages of peer-led Interpersonal Communication are that it:

- (i) Has greater credibility than other outreach-led communication strategies
- (ii) Uses familiar language and the experience of having “lived the life” to ensure better affinity building around the message, reduced stigma and an environment of sharing
- (iii) Facilitates a higher degree of acceptance and ownership of the programme goals amongst the population

#### 3.3.2.1.1 Types of peers

Peers may be of two types:

- (i) **Cluster Link Workers:** Cluster Link Workers themselves representing from the same village can be best resources and can be the best motivators for others in the programme.

- (ii) **Volunteers:** These are among the mothers, High Risk Groups or youth who have been sensitised and have seen the result of services they have accessed. They can be supported with Cluster Link Workers to volunteer for meetings with target population.

**(the details of selection of Cluster Link Workers is included in the section under human resources in this chapter)**

#### *3.3.2.1.2 Interpersonal Communication tools*

The Interpersonal Communication tools placed in Annexure 3 are based on three thematic areas:

1. **Body Mapping** – which enables the participants to understand the risk and generate information on perceiving the risk level.
2. **Service Mapping** –which enables the participants to get information about various services and their location.

**Vulnerability Mapping** –which enables the participants to understand the measures which can reduce their vulnerability.

#### *3.3.2.1.3 Contents of the Behaviour Change Communication sessions:*

The Interpersonal Communication and Behaviour Change Communication sessions should focus on following areas:

1. How to trigger risk perception i.e. what they do in their profession or while engaging in a risky sexual act or injecting act carries risk.
2. How to enable target population to understand that what measures they can adopt and practice so that their risk level becomes minimum or nil.
3. Why is it important that they get medical checked up for other ailments including Sexually Transmitted Infections, because they need to be productive, earning money for their family. In case, they fall ill, their income may get affected.
4. To make them understand how Sexually Transmitted Infections can be problematic for themselves as well as for their partners. Everyone of us wants their partner to be healthy to support us. Hence, it is important to get the Sexually Transmitted Infections treatment done from a qualified practitioner, complete the treatment and seek partner treatment as well.
5. To make their skills enabled on how to use a condom in different conditions, conditions in a dark room, with a partner who is alcoholic, conditions with a male partners etc.
6. To make their skills how to tell these information to a friend and help him to reach the programme and seek health services whenever required.
7. Provide information about whole range of services, its need and the location of services available near to them.
8. Provide information on safer injecting practices, abscess treatment at the nearest Primary Health Centre or Community Health Centre and advantage of Opioid Substitution Therapy.

#### **3.3.2.2 Mid-media**

Mid-media serves to widen exposure, increases programme awareness and recall of programme services and helps generate demand. Synchronising mid-media activities with other services like health camps helps reinforce key messages and build sustained engagement. These can be organised by State AIDS Control Societies as a part of the folk media activities.

### 3.3.3 Condom Programme

Link Workers Scheme can have provision of male and female condoms (if only the female condom programme is available in the District) at the sub-centres, with the Accredited Social Health Activist, Auxiliary Nurse and Midwifery and Cluster Link Worker in the area.

It is suggested that under Link Workers Scheme free condom shall be made available for following purposes:

- (i) Condom demo and re-demo purposes.
- (ii) Free condoms will be provided to the High Risk Groups and clients through.
- (iii) Free condoms for other target population will be provided through Accredited Social Health Activist and Auxiliary Nurse and Midwifery.

The suggested formula for calculating the requirement of free condoms for each Cluster Link Worker is as follows:

- (iv) For demo and re demo purposes: Number of outreach sessions per month x number of month + 10% wastage
- (v) For distribution among High Risk Groups and their clients: Number of total High Risk Groups and their clients listed last two yrs multiplied by 72 per person + 10% wastage

The suggested modalities for Social marketing of condoms are as below:

- a. Identification and preparation of potential outlets list.
- b. Procurement of condoms as per the requirement of the outlets for at least two months from distributors or agency.

The outlets shall be a mix of both traditional and non-traditional outlets. The training of outlet holders may be taken up for better rapport building with the clients, display of products etc.

### Bio-medical Component

Under this component, the focus may be on increasing risk perception, provision of risk reduction measures through treatment, counselling and referrals and further augment activities to reduce the risk environment. These services include:

1. Prevention, Treatment and Management of Sexually Transmitted Infections or Reproductive Tract Infections
2. Syphilis Screening
3. Linkage with HIV related services:
  - a. HIV screening
  - b. HIV care and treatment
  - c. Post exposure prophylaxis
4. Linkage with other health services:
  - a. Prevention, screening, treatment and management of Tuberculosis Bacilli
  - b. Family planning services

However, all these services are linked to the existing service providers. Hence, a minimum package of service is suggested as below with clear roles and expected outcomes.

What	How	Responsibility	Expected outcome	Measurable indicators
Sexually Transmitted Infections screening and treatment	Through existing providers	Private or Govt. trained doctors	Increase in clinic footfalls and Sexually Transmitted Infections treatment	(i) Decline in Sexually Transmitted Infections burden among target group
Syphilis screening	Through existing facilities		Decline in syphilis burden	(i) Decline in syphilis burden



Tuberculosis Bacili screening and treatment	Through Tuberculosis Bacili screening facilities	Tuberculosis Bacili microscopic centres	Increase in screening and treatment compliance	(i) Reduction in Tuberculosis Bacili burden among target group
HIV testing	Through HIV testing facility	Nurse or Counsellor	Increase in HIV testing and decline in HIV burden among truckers over a period	(i) Increase in HIV testing among High Risk Groups and their partners (ii) Decline in HIV burden among target group
HIV care and treatment	Through nearest Care and Support Centre	Care and Support team	Increase in adherence to treatment among HIV positive clients	(i) Increase in adherence and increase in quality of life
Family Planning services	Through nearest Sub-Centre or Primary Health Centre	Auxiliary Nurse and Midwifery or Accredited Social Health Activist	Increase in acceptance of FP services	(i) Increase in triple protection deliverables (protection against child bearing, Sexually Transmitted Infections and HIV)

### 3.3.5 Linkages with Other HIV Services

Since all services under Link Workers Scheme are expected to be linked with existing services. It is important that how the linkage with other HIV services will be planned and monitored by the project:

#### 1) Planning of referrals to other HIV services:

- A list of HIV services (HIV testing, Tuberculosis Bacili Screening, Antiretroviral, Opportunistic Infections management) may be made available with the project along with contact details, service timings.
- The nature of services (whether free of cost or charged services).

#### 2) Referrals:

- Referrals being made to government run HIV testing and Antiretroviral facilities may be done based on the existing National AIDS Control Organisation protocols.
- It is suggested that two sets of referral slips may be provided to the clients – so that one is retained with the facility for future verification.
- The list of referrals may be shared with the facilities at the end of the month so that the staff in the facility can track the referrals and assign unique numbers in cases where the clients have accessed services with or without referral slips.

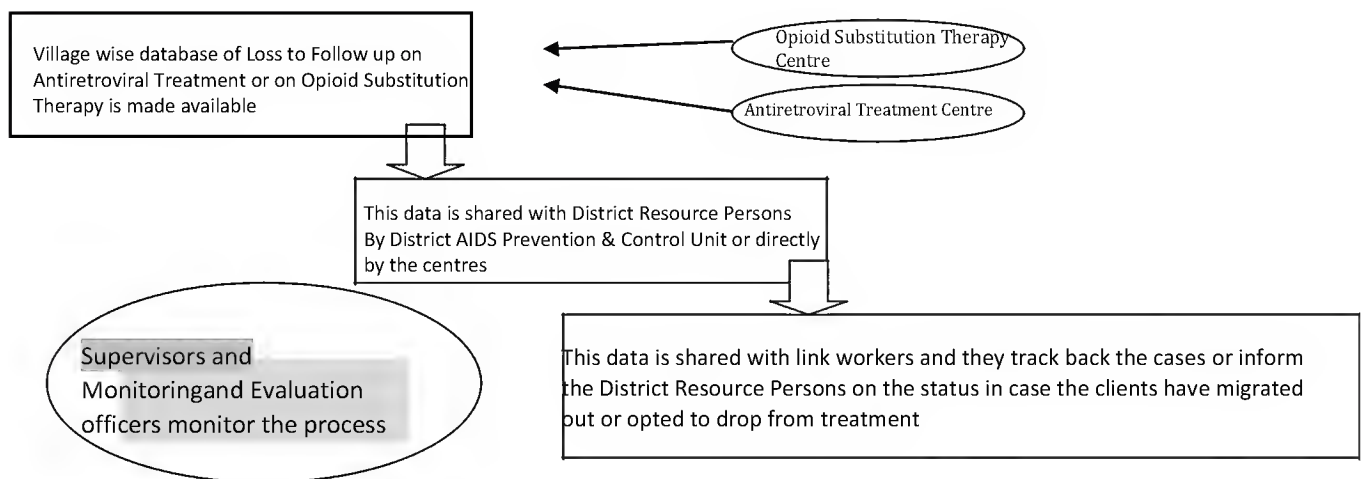
A sample format for referral and linkage register to be maintained at District level is provided at Annexure 4.

#### 3) Referral monitoring:

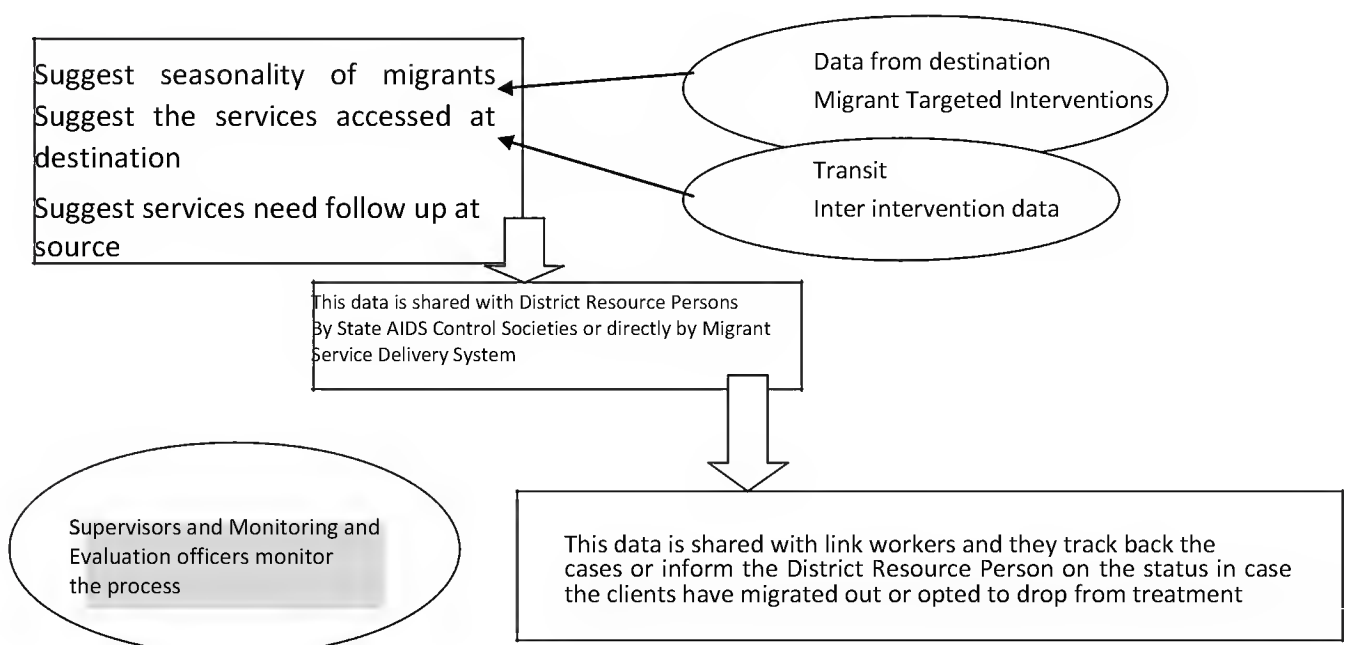
- In case of government run HIV testing and Antiretroviral facilities the line list with unique numbers may be collected from the facilities and the same is updated in the project Management Information System.
- The summary of the figures among referred who availed services are reported in the monthly reports. A sample format for monitoring referral and linkages is provided at Annexure 5.

## Positive Prevention Services:

It may be more efficient to change behaviour among fewer HIV+ individuals than many HIV+ individuals. The goal of positive prevention services to keep People Living with HIV physically and mentally healthy and ensure prevent transmission of HIV to other people as well as increase their participation in societal purposes. These can be done by ensuring that they are receiving Antiretroviral Treatment, psychosocial counselling regularly. Besides their engagement in the programme will motivate them and will increase their self esteem. Similarly, linkage to network and support groups will help them to share their thoughts better. For tracking of Loss to Follow Up especially those on Opioid Substitution Therapy and Antiretroviral Treatment following mechanisms to be followed up:



**For tracking of migrants who migrate to high prevalence States and are coming back once or more than once a year following mechanisms to be followed up:**



### 3.3.6 Linkages with Other Health Services

It is important to have strong linkage with existing public health system for following services:

- (i) Syphilis screening – this may be provisioned along with HIV testing services or may be offered as a separate service to those who are being treated for Sexually Transmitted Infections.
- (ii) Tuberculosis Bacili screening – this may be offered to clients with suspected or history of primary, secondary tuberculosis.
- (iii) Abscess management– this may be offered to Injecting Drug Users clients with abscesses due to injecting drugs.
- (iv) Family Planning – this may be offered to all clients who are being referred to the sub-centres or to the nearest public health facilities. Since male or female condom use for family planning reduces the risk of transmission of HIV and Sexually Transmitted Infections.

It is very important that for linkages with other health services, the District level Non-Governmental Organisation need to take up following activities:

1. Sensitisation of District Administration, District Health Society, District level Non-Governmental Organisation on the scheme especially the role expected from other institutions.
2. The DRP need to sensitise District Health Society, Block Medical Officers, Child Development Project Officers, District Social Welfare Officer etc. about the support expected from Accredited Social Health Activist, Auxiliary Nurse and Midwifery and Anganwadi Workers in ensuring service linkage in all villages. But due to epidemic importance the Link Workers Scheme will work in selected 100 (maximum) in a District.
3. There is a need to train and sensitise the Accredited Social Health Activist workers, Anganwadi Workers through regular meeting at Block and District level especially through the ongoing platforms of review meeting, Accredited Social Health Activist training or any other workshops.
4. Similarly, the Direct Observed Treatment and Short Term Chemotherapy providers, Senior Tuberculosis Laboratory Supervisors need to be sensitise with support of Tuberculosis Bacili programme staff to ensure that the coordination is improved at village level for HIV-Tuberculosis Bacili cross referrals.
5. Block supervisors should attend the monthly or weekly meeting of Accredited Social Health Activist, Auxiliary Nurse and Midwifery, Anganwadi Workers in their own Blocks and neighbouring Blocks to ensure that in a quarter at least all Block level meetings are attended. During these meetings – the zonal supervisor is expected to share the performance of the Block in terms of coverage of link workers scheme, the challenges faced and expected support from Health and Women & Child Development departments.
6. Similarly, the District Resource Person is expected to attend monthly meetings or any other meeting with District Administration – shall share the progress of the scheme, role expected from various authorities.

7. The District Resource Person and Block supervisors during these meetings may concentrate on sensitising and training the staff so that they can work better with Cluster Link Workers.

### **3.3.7 Implementing Health Camps**

These are specific events organised at Panchayat Level especially during festivals when migrants return to their villages. This helps everybody to get their health checked up as well as undergo HIV counselling and testing. These shall be organised with prior consultation with State AIDS Control Societies and local District Health Society. So that there is no duplication and necessary support can be provided. Ideally the doctors, medicines and Information, Education and Communication materials, condoms are to be provided by District Health Society and State AIDS Control Societies shall provide testing and counselling support. Detailed guidelines on conducting health camps is available with State AIDS Control Societies.

### **3.3.8 Stock Management**

The stock and issue register for the free condoms, needles and syringes may be maintained by the supervisor for each Taluka level. There will be a sub stock register for each Cluster Link Worker. At the end of each month the supervisor needs to make each sub-stock register as NIL and get back all stocks available. This will make the central stock maintenance and monthly reporting easy. Accordingly inform the nearest Targeted Interventions from whom the needles and syringes are used for distribution and nearest Block Primary Health Centre for free condoms.

There is a need to be maintain the list of items by their expiry dates. Free condoms with early expiry may be consumed first followed by late expiry ones. In case of expired condoms, the same may be submitted to nearest sub-centre for proper disposal and striking out from the stock register. A sample format for stock and issue maintenance by Cluster Link Workers is attached at Annexure 6 and a format for maintenance at District level is attached at Annexure 6a.

### **3.3.9 Bio-Waste Management of used Needles and Syringes**

The needles and syringes collected from the field or from the Injecting Drug Users or their family members may be maintained in a separate register and shall be kept in a puncture proof plastic container with medium size opening. This container may be carried with utmost care to the nearest Targeted Intervention which will carry out proper disposal as per Waste Disposal Guidelines.

### **3.3.10 Advocacy Activities**

These activities are aimed at creating an enabling environment so that the stakeholders are sensitised about project activities, target population, vulnerabilities associated with the target population. These activities shall be planned based on the stakeholders analysis and their role. This shall be planned with aim at leveraging resources and support of District administration, other line departments so that the planned activities under this project are carried out. These meetings range from local body, Block and District level meetings. These meetings are to be attended by Block Development Officer or District Collector and other senior officers of the Block or District, Non-Governmental Organisation representatives working in the Block or District so that they contribute meaningfully. Technical Support Unit-Project officer or State AIDS Control Societies officers may also attend this meeting and should provide an overview of the need of the project in the area.

### **3.3.11 Local Village level Meeting**

The villages are to be selected based on the need for sensitisation, preferably new villages, villages with high outmigration, villages planned to set up information centre etc. These meetings are to be planned with other activities of the project such as planning health camps, Information, Education and Communication folk activities, mothers meeting and Self Help Group meetings. These meetings are to be attended by Panchayat leaders, Village Health and Nutrition Sanitation Committee members, Auxiliary Nurse and Midwifery, Accredited Social Health Activist, Anganwadi Workers, Self Help Group members and other members. The meetings are planned to mobilise support for different activities. Hence, before the meetings all the possible stakeholders are contacted and sensitised about the project so that during the meeting they participate and contribute meaningfully.

### **3.3.12 Stigma Reduction Activities**

Each District with Link Workers Scheme shall plan a District level sensitisation activities in close association with State AIDS Control Societies and District Health Society. Activities such as training of health care providers, Integrated Child Development Scheme staff, Panchayati Raj and Labour department officials may be planned in coordination with Mainstreaming Division of State AIDS Control Societies. The aim of this activity is to address stigma and discrimination associated with staff of different service delivery points and sensitising them about the need for their contribution in implementing various HIV or AIDS related activities including Link Workers Scheme. The Link Workers Scheme team shall prepare a broad agenda and ensure participation from State AIDS Control Societies in this event. Similar activities can either be planned at Block or District level.

### **3.3.13 Coordination and Facilitation of People Living with AIDS or People Living with HIV Networks**

The Link Workers Scheme team is expected to work closely with People Living with AIDS or People Living with HIV networks to involve in various activities so that there is an inclusive environment and they contribute in sensitising the stakeholders about issues associated with HIV or AIDS programme in the area. They may be involved as speakers in various forums and meetings. Any other activities may be planned in close coordination with State AIDS Control Societies and local networks.

### **3.3.14 Cluster Link Worker Award**

This is a motivational activity to promote Cluster Link Workers in a District. The Cluster Link Workers are expected to contribute effectively in the programme by strengthening liaison with other stakeholders, improve service access by target population. These awards are expected to be announced during the World AIDS Day functions planned for the District or any other important day in the District. A committee chaired by District Nodal Officer for HIV or AIDS shall decide the five Cluster Link Workers who will be felicitated. The other members of the committee shall be representative/official from District AIDS Prevention & Control Unit, Targeted Interventions division State AIDS Control Societies, Technical Support Unit, local civil society organisation, District Social Welfare Officer and as decided by the Chairman of the committee. The criteria for selection of these Cluster Link Workers shall be displayed visibly in the notice board of the implementing agency, District administration and District Health Society offices.



The award will consist of an appreciation certificate along with Demand Draft (refer the budget for details) in the name of recipient. The minimum criteria for selection of five Cluster Link Workers will be as follows:

1. Cluster link Workers who were employed by the District Non-Governmental Organisation fulfilling basic eligibility criteria of education and experience as noted in this Guidelines.
2. The Cluster Link Workers shall have completed one year (12 months) of service is eligible for the award.
3. The Cluster Link Workers shall have good conduct and punctuality over last 12 months.
4. The Cluster Link Workers shall have excellence in performance against the targets for the programme.
5. New initiatives or efforts taken by the Cluster Link Workers to strengthen the programme or to achieve the project objectives.
6. The Cluster Link Workers shall not be involved in any other activities which are detrimental to the project such as in any conflict of interest to the organisation or any members of the committee or indulged in any financial misappropriation.

The reports of the award function shall be circulated widely in local newspapers and shall be published in District Non-Governmental Organisation's annual report, State AIDS Control Societies newsletter. A selected number of these reports will also be published at National level through National AIDS Control Organisation newsletter.

The decision to arrange the award ceremony of the five Cluster Link Workers is sole responsibility of District AIDS Prevention & Control Unit and State AIDS Control Societies. Technical Support Unit is expected to provide necessary support.

#### **Responsibilities of Link Workers Scheme Non-Governmental Organisation:**

- (i) Non-Governmental Organisation has to ensure that necessary documents and records of staff is available for the process.
- (ii) The Non-Governmental Organisation's responsibility is also to ensure the coordination, communication among all these stakeholders for appreciating the effort of Link Workers Scheme staff and the Non-Governmental Organisation has to complete this task before end of December in each financial year.
- (iii) The activity shall not be carry forwarded to the next financial year.
- (iv) The case studies of all these recipients shall be compiled appropriately. The case studies shall be available at the Link Workers Scheme Non-Governmental Organisation and copy shall be shared with State AIDS Control Societies.

The final list of Cluster Link Worker Award recipient names to be displayed in State AIDS Control Societies office and website for public information at the state level. State AIDS Control Societies to send the few best case studies to National AIDS Control Organisation out of total case studies received from all Link Workers Scheme programme in the state.

#### **Structural Component**

This component is important from the point of bringing a positive and enabling environment where various target groups can engage with the project services in a non-stigmatising and non-compelling environment everyone finds the service quality is better. To establish a structural component, following services may be considered:



1. Sensitisation of the local Panchayat leaders and other stakeholders about the services being provided by the scheme. The pitch may start with importance of linking Antenatal Care mothers, Tuberculosis Bacili patients with HIV services initially. Later on the vulnerability of migrants and High Risk Groups may be used to sensitise.
2. Mobilising vulnerable groups in the form of Self Help Groups and Youth Clubs to demand and access services and participate in its delivery.
3. Involving other government service functionaries or programme staff as volunteers so that they will fully register the vulnerable groups in their programme and delivery services even without active involvement of the Cluster Link Workers.
4. Mobilising other Non-Governmental Organisations or organisations who also target the same vulnerable and risk groups for various other services can be sensitised about the need of motivating these group of clients for better health seeking behaviour even through their programme activities.
5. There shall be efforts to transfer knowledge and skills by District Resource Persons, Zonal Supervisors to the other staff at ground level so that the entire District is covered under the programme in spite of the presence of the scheme limited to a number of villages.

*Group Formation by Cluster Link Workers:*

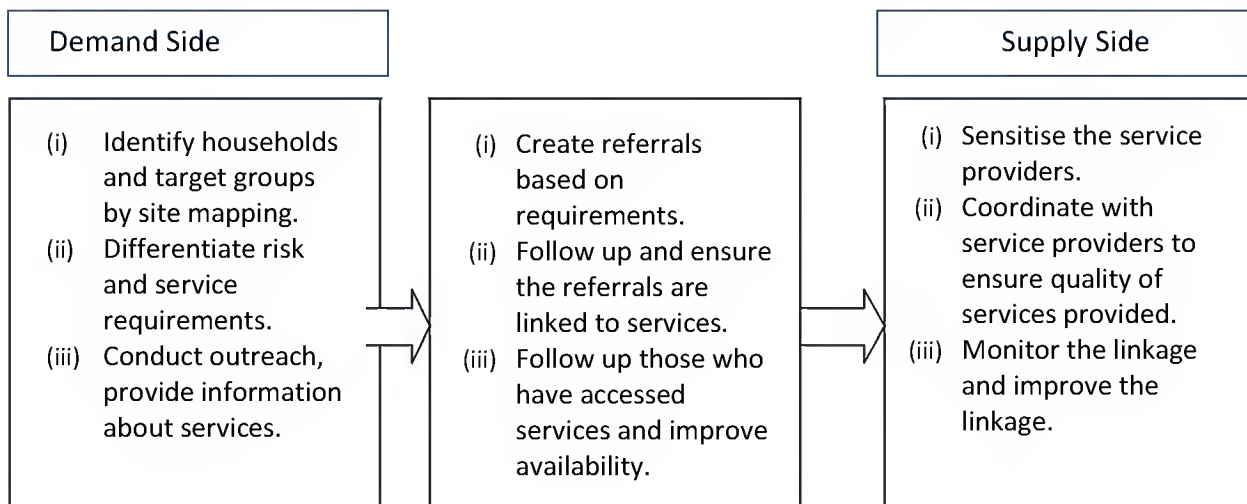
There are enough evidence suggesting on peer group decisions influencing one's health seeking behaviour. Especially with respect to the HIV programming, the peer groups drive certain norms which also influence individual risk taking behaviour. Hence it is proposed that Cluster Link Workers shall form at least two groups in each year of the programme in a village. These groups may be formed among the spouses, adolescents, youths. The purpose of the group is to enable them to take decisions about their health and health seeking behaviours.

The following steps may be adopted:

- (i) The existing platforms of Self Help Groups, Village Health and Nutrition Day meetings, Adolescent meetings to be tapped to provide knowledge and skills for minimising risk taking behaviour and improving health seeking behaviour.
- (ii) On regular interaction it would be found that there would be champions or volunteers who will be eager to participate in the programme for various purposes such as working as condom depot, person who refers clients for various services, person who helps during health camps.
- (iii) These champions or volunteers will be sensitised to further transfer similar skills to their friends, in this process a group can be formed and they can participate in various activities under the scheme.

### 3.4 Programme Management:

The Link Workers Scheme is a District implementation model and is an important prevention intervention targeting various at risk and vulnerable groups. Since no service delivery points are created under this scheme it is essential that the outreach component of the scheme is strong enough to create demand for services and the services are made available.



The important elements of the effective programme management in Link Workers Scheme:

#### Demand Side:

- (i) Target specific and differentiation of risk of population is required to design the intensity of outreach services by the cluster link workers.
- (ii) Ensure the services are provided in a manner which does not breach confidentiality of the client.

#### Supply Side:

- (i) Ensure that the work done by Auxiliary Nurse and Midwifery, Accredited Social Health Activist or Anganwadi Workers is not taken over by the Cluster Link Workers. The purpose of follow up of Antenatal Care mothers for HIV testing and other related services is to link up these mothers with HIV related services.
- (ii) Coordinate with service providers like Medical Officer of Primary Health Centre to ensure routing of Mobile Medical Units for the village (if available), availability of doctors and medicines for organising health camps, availability of condoms and Information, Education and Communication materials for distribution.
- (iii) Effective linkage and referral monitoring by maintaining referral slips by the Primary Health Centre or Sub centre staffs and ensure cross checking.

### 3.5 Human Resource Management

The human resources provisioned under the scheme at District level comprises following staff and their roles in the programme. (detailed about process of recruitment is annexed at Annexure -9)

Position	Roles and Responsibility
District Resource Person (1 per District)	<ul style="list-style-type: none"> <li>(i) Overall responsibility of the programme in the District.</li> <li>(ii) Supervise works delegated to other member of the team and mentor them.</li> <li>(iii) Facilitate recruitment of staff as per the Guidelines in case of vacancies.</li> <li>(iv) Development of District implementation plan ensure approval by competent authorities.</li> <li>(v) Monitor the implementation of District plan and submit progress reports as per requirement.</li> <li>(vi) Ensure training of all staff when they join and training by State Training and Resource Centres.</li> <li>(vii) Make field visits, meet and coordinate with stakeholders at District and Block level to address issues related to implementation of the scheme.</li> <li>(viii) Support State AIDS Control Societies or District AIDS Prevention &amp; Control Unit in implementing various activities such as Condom Programme, Folk Media Activities, Mass Media campaigns, Health camps etc.</li> <li>(ix) Work with various government departments ensuring that the target groups are enrolled, receiving necessary services if they are eligible.</li> <li>(x) Play key role in advocacy at all levels against stigma and discrimination.</li> <li>(xi) Compile reports and ensure analysis by Monitoring and Evaluation assistant for programmatic gaps.</li> <li>(xii) Submit programme and financial reports on time to State AIDS Control Societies or Technical Support Unit or District AIDS Prevention &amp; Control Unit or any other agency.</li> </ul>
Monitoring and Evaluation cum Accounts Assistant (1 per District)	<ul style="list-style-type: none"> <li>(i) Timely collection of various reports from the field level staff, financial documents analyse them and prepare monthly report indicating progress, gaps</li> <li>(ii) Ensure timely submission of reports to State AIDS Control Societies or Technical Support Unit or District AIDS Prevention &amp; Control Unit or any other agency</li> <li>(iii) Ensure procurement process is followed as per directions of State AIDS Control Societies</li> <li>(iv) Ensure all financial norms, financial documents are maintained as per norms</li> <li>(v) Ensure orientation of staff about different reports, financial transactions.</li> </ul>
Zonal Supervisor (1 per 10-12 Cluster Link Workers)	<ul style="list-style-type: none"> <li>(i) Supervise works delegated to cluster link workers and mentor them.</li> <li>(ii) Facilitate in site mapping, participate in Taluka and Panchayat level meetings to sensitise about the work being done under the link workers scheme.</li> <li>(iii) Ensure regular supply of condoms and needles and syringes (wherever required)</li> <li>(iv) Coordinate with other programme staff in the field (Targeted Interventions, Auxiliary Nurse and Midwifery, Accredited Social Health Activist, Anganwadi and other staff including staff of other Non-Governmental Organisations who are working with the same target population)</li> <li>(v) Maintain rapport and coordinate with local govt. health facilities.</li> <li>(vi) Reconcile the referral slips at least once a month and update referral register of the area and inform Cluster Link Workers about the gaps.</li> <li>(vii) Maintain stock and issue register by reconciling the sub-stock register.</li> <li>(viii) Facilitate formation of condom depots, information centres and supervise their functioning.</li> <li>(ix) Coordinate and facilitate with other govt. departments at Panchayat and</li> </ul>

	Taluka level ensuring the eligible target groups are enrolled under various schemes and are accessing benefits.
Cluster Link Workers (maximum of 20 for 100 villages – 80 main villages as per the Guidelines and 20 tagged villages)	<ul style="list-style-type: none"> <li>(i) Conduct village-level site mapping (vulnerability mapping, health services or facility mapping, and household mapping).</li> <li>(ii) Understand the migration patterns (both in and out migration) in the local community.</li> <li>(iii) Reach out to the un-reached High Risk Individuals or groups and vulnerable young people with information and skills relevant to HIV prevention and risk reduction.</li> <li>(iv) Provide relevant information regarding condom use, using innovative means that are contextually, locally and culturally appropriate.</li> <li>(v) Work towards reducing stigma and discrimination in the community by facilitating involvement of HIV positive people, community groups like Self Help Groups, Panchayati Raj Institution and Village Health and Sanitation Committee, and bringing into focus and addressing gender dimensions of stigma and discrimination.</li> <li>(vi) Advocate with identified stakeholders for creating an enabling environment (and reducing stigma and discrimination).</li> <li>(vii) Maintain rapport with local health units and facilitate access to services.</li> <li>(viii) Have knowledge about the key health facilities in the vicinity, at First Referral Unit and the District level, and possess necessary information about the services available at the identified facilities.</li> <li>(ix) Work towards reducing barriers to accessing services and promote Sexually Transmitted Infections management and partner notification.</li> <li>(x) Coordinate the linkage between communities and service institutions (especially Integrated Counselling and Testing Centre, Primary Health Centre or Community Health Centre, Reproductive Tract Infections or Sexually Transmitted Infections clinic and District hospital).</li> <li>(xi) Identify and train volunteers.</li> <li>(xii) Collect monthly data from condom depot holders.</li> <li>(xiii) Prepare monthly reports for his/her area according to a pre-defined format.</li> </ul>

### Take home messages:

- (i) From HIV programme point of view, the at risk population require equal priority on behavioural, bio-medical and structural components of the project.
- (ii) Outreach and one to group Behaviour Change Communication sessions are cornerstone of behavioural component. Outreach shall be location and time specific, prepared by the link workers once in every quarter.
- (iii) Free condoms demo, re-demo and distribution in addition to social marketing of condoms is essential to ensure availability of condoms in the project area.
- (iv) Linkages and access to services are important from the point of addressing risk environments
- (v) Linkage with other HIV and health services further brings in inclusive approach for addressing risk.

## CHAPTER 4: Reporting and Documentation and Quality Assurance Mechanism

In this chapter, following areas are covered:

1. What are the various areas of documentation and reporting
2. What are the quality parameters and mechanisms of quality assurance
3. Monitoring and evaluation – role of State AIDS Control Societies, Technical Support Unit
4. Performance Indicators

### 4.1 Documentation and Reporting

#### 4.1.1 Documentation

- (i) The project is expected to maintain daily records of all outreach activities, referrals for Sexually Transmitted Infections treatment, HIV counselling and testing, enabling activities, and condom social marketing.
- (ii) The project is expected to maintain profiles of all staff and minutes of planning and review meetings.
- (iii) All activities in the project is expected to be documented as per the standardised documentation formats.

#### 4.1.2 Reporting

- (i) A monthly report for as per requirement of National AIDS Control Organisation will require to be reported as per required dateline.

The following set of reporting formats would be used to document, report various activities under the scheme.

Name of the document	Who prepares	How frequently
Line listing of migrants and other categories	Cluster Link Workers supported by Supervisor	As and when a new contact is made (Annexure 1), For migrants (Annexure 2)
Referral and Linkage	Cluster Link Workers supported by Supervisor	As and when a person is referred (Annexure 4)
Referral and Linkage monitoring	Supervisor supported by District Resource Persons and Monitoring and Evaluation cum Accounts Assistant	On fortnightly basis (Annexure 5)
Stock and Issue	Cluster Link Workers supported by Supervisor	On a weekly basis (Annexure 6)
Stock and Issue at District	Monitoring and Evaluation cum Accounts Assistant	On a fortnightly basis (Annexure 6a)
Field visit	Supervisor, District Resource Persons	As per requirement (Annexure 7)
Meeting	Any level of staff	As per requirement (Annexure 8)
Human Resources	Monitoring and Evaluation cum Accounts Assistant	Monthly Once (Annexure 10)
Monthly report	Monitoring and Evaluation cum Accounts Assistant	As per requirements (Annexure 11)
Accounts and Finance	Monitoring and Evaluation cum Accounts Assistant	As per requirements
Monthly analysis report for each Supervisor	Monitoring and Evaluation cum Accounts Assistant supported by District Resource Persons	Weekly once for supervisors on rotation basis

## 4.2 Quality Assurance Mechanisms

As part of the project management, the National, State and Project Level staff will manage certain key quality assurance mechanisms in terms of the inputs, processes and outputs of the Link Workers Scheme.

### 4.2.1 Defining quality parameters

The following quality parameters would be defined for input level:

Quality Parameter	Role and Responsibilities
Standardised training and field level inputs for Intervention	National AIDS Control Organisation
Selection of staff as per Terms of Reference	Implementing Partners
Training of staff as per prescribed Guidelines	Implementing partner in coordination with State Training and Resource Centres
Supply of condoms, needles and syringes as per prescribed Guidelines	State AIDS Control Societies in coordination with local District Health Society
Number of visits made and addressed gaps in the programme	Technical Support Unit or State AIDS Control Societies or National AIDS Control Organisation

The following quality parameters would be defined for process level:

Quality Parameter	Role and Responsibilities
Average number of target population reached through outreach sessions	Cluster Link Workers
Number of target population referred by outreach team are attending clinic	Cluster Link Workers and Local health care providers including Govt. facilities
Number of target population amongst the clinic attendees were treated for Sexually Transmitted Infections	Govt. and private trained providers

The following quality parameters would be defined for output level:

Quality Parameter	Role and Responsibilities
Number of target population reached with services – clinic, counselling and HIV testing	Implementing Partners
Reduction in Sexually Transmitted Infections burden among target population at least measured after two years	Implementing Partners
Increase in condom sales through social marketing as per the target of outlets after six months	Implementing Partners
Increase in condom use during last sex as measured during IBBS	National AIDS Control Organisation
Decline in HIV burden among High Risk Groups	National AIDS Control Organisation



and their partners over a period	
Improved Antiretroviral adherence among target population	National AIDS Control Organisation

#### 4.2.2 How to measure quality parameters

It has been noted that measurement of quality parameters are seen as proxy of outcome or output indicators. But it is important to ensure that there is a system to measure the inputs and processes as well. Hence, it is important that the inputs and processes need to be continuously monitored in order to ensure better outputs.

For example, in a link workers scheme, if the village selected is not feasible, if the Cluster Link Workers are not from the same area, if adequate number of outreach sessions is not being conducted, if in each quarter no new members are contacted, if there is less clinic footfall **-then the output and outcome would be affected.**

Hence, it is important that the measurement of quality shall start with each activity, considering that each activity itself would impact the output. This sensitivity needs to be built in within each staff and shall not be a top-down approach. **Measurement of quality parameters may be part of field visit checklists of project team, may be part of the technical and management team's review.**

The Technical Support Unit may come up with Standard Operating Procedures for each of these above parameters with clear cut operational definition, operational mechanism and reporting norms. Thus there is uniform understanding across different teams and members within the team. Performance benchmarks may be developed taking into account local scenario to further measure outputs and inputs better.

### 5.1 Monitoring and Evaluation

The projects will be monitored regularly by the Technical Support Unit. The robustness of data collection and the intervention level as well as at the national level (de-centralised and centralised levels) will aim to inform national intervention quality and design.

- (i) The officers or team visiting the projects will have a clear agenda for the visit and will be based on the supervisory check list developed by Technical Support Unit or National AIDS Control Organisation.
- (ii) All visits will be documented and the suggestions or recommendations shared in writing with the implementing organisation and National AIDS Control Organisation
- (iii) Suggestions or recommendations made by the monitoring officer or team will be implemented by the organisation
- (iv) All documents, reports and plans maintained by the project will be open for scrutiny during these monitoring visits
- (v) Staff reviews will be part of the monitoring process
- (vi) The data must be used to correlate the progress made by the project
- (vii) Quarterly reviews are to be used to evaluate trends and improvements.
- (viii) The project preferably be evaluated by an external agency or evaluator. The evaluation tool and manual can be developed by technical team.

### 5.1.1 Performance Indicators

This set of indicators is suggested to monitor the performance of the link workers scheme.

- (i) These indicators are based on the assumptions that the Interventions have appropriate facilities and staff in place as required in the Guidelines.
- (ii) The indicators in this section are broken out component-wise – e.g., outreach, condoms, Sexually Transmitted Infections or Clinical, enabling environment.
- (iii) The “denominator”: The denominator represents the basis for assessing the performance. It captures the annual actual coverage target on the ground and has been established based on the estimates worked out for a particular Cluster Link Worker.
  - In case of on-going interventions it is the sum of the current coverage and the annual coverage targets established based on the revalidation.
  - In case of a new interventions, the denominator is the coverage targets based on the calculations in Chapter 3.

### 6.1 Role of Stakeholders

The collaborative coordination of the HIV response and management of implementation by National AIDS Control Organisation and implementing partners ensures that the national programme is dynamically designed to maintain relevance; aligned to implementation principles of efficiency and effectiveness and closely monitored to ensure that opportunity gaps are addressed. These processes give rise to additional and complementary capacity building and mentorship initiatives aimed at strengthening and sustaining quality coverage of at risk and vulnerable populations in rural settings with prevention interventions. To facilitate National level implementation of the Link Workers Scheme following stakeholders will be involved as mentioned below:

- (i) Policy Makers (Ministry of Health & Family Welfare through National AIDS Control Organisation, Ministry of Women & Child Development, Ministry of Rural Developments, State Governments through State AIDS Control Societies).
- (ii) National Technical Working Group for Link Workers Scheme, Technical Support Unit
- (iii) Implementing partners (Non-Governmental Organisations, Community Based Organisations, State Training and Resource Centres, Private Health Organisations etc.)

The detailed role for various stakeholders may be as follows:

#### National AIDS Control Organisation:

The National AIDS Control Organisation being the nodal agency for the Ministry may play important role in steering the Link Workers Scheme. The scheme would be managed by Targeted Interventions Division at National AIDS Control Organisation. These include:

- (i) Evidence building around estimates, prevalence and behavioural parameters of at risk and vulnerable population in rural settings including their service utilisation pattern such as Antiretroviral Treatment uptake, Tuberculosis Bacilli and HIV co infection rates.

- (ii) Guide implementing partners for implementation of programme in consonance with National Guidelines.
- (iii) Guide implementing partners in impact and outcome assessment and support for mid-course corrections.
- (iv) Provide guidance in developing training curriculum, training resources, communication materials.
- (v) Provide guidance in ensuring supply of condoms, needles and syringes for the programme and coordination among various services and programmes among Key Populations.

**Other Ministries (Ministry of Women and Child Development, Ministry of Rural Development):**

The Ministry of Women and Child Development, Ministry of Rural Development may play the role in creating enabling environment which addresses the vulnerability of women in sex work, children orphaned due to HIV or AIDS and other vulnerable male population, improves the working condition of Cluster Link Workers by ensuring service linkages by sensitising their departmental staff.

**State Governments through State AIDS Control Societies:**

The role of State governments may be to facilitate the smooth implementation of the programme as per National Guidelines. The scheme will be managed by Targeted Interventions division at State AIDS Control Societies. The broad areas include:

- (i) Contract management and timely fund flow by ensuring that the attrition of Cluster Link Workers is not attributed due to poor fund flow mechanism.
- (ii) Conduct regular bimonthly or quarterly meetings with District level Non-Governmental Organisations, District AIDS Prevention & Control Units to review and understand field challenges and gaps and provide inputs for any mid course corrections to National AIDS Control Organisation.
- (iii) Conduct field visits to the implementing Districts to review and provide technical inputs to the programme.
- (iv) Ensure coordination amongst all partners working in a particular District especially in terms of High Risk Groups, Bridge Populations and vulnerable populations.
- (v) Ensure free condoms, Information, Education and Communication materials as per requirement of the scheme is available from the Districts or Block Health Society under National Health Mission.
- (vi) Ensure that the folk troupe activities, condom social marketing campaigns and migrant health camps are conducted in 80% of the project area in a District each year.
- (vii) Consider the mainstreaming of programmes in all Districts covered in the scheme in a synergetic manner so as to address the issue of vulnerability.
- (viii) Ensure that the staff conducting the scheme is trained and their skills are built to implement the activities effectively by the State Training and Resource Centres or any other arrangement where State Training and Resource Centres is not available.
- (ix) Select Implementing Non-Governmental Organisations as per National Guidelines.
- (x) Information, Education and Communication division to plan number of mid-media events, adequate supply of Information, Education and Communication materials, Link Workers Kit for use by the District level Non-Governmental Organisation staff. All Information, Education and Communication related activities are to be carried out in coordination with Information, Education and Communication division of State AIDS Control Societies or National AIDS Control Organisation. These activities shall

ldeally be planned in the Annual Action Plan to ensure that the District level Non-Governmental Organisations are supplied with the materials as per requirements.

### **Mainstreaming of services by State AIDS Control Societies:**

Since the scheme will focus in selected villages and Blocks as well as selected Districts, it is essential that efforts must be made to transfer similar skills and knowledge to Accredited Social Health Activist, Auxiliary Nurse and Midwifery and Anganwadi Workers through respective ministries as well as including similar activities in their annual plans in phases.

It is important that all divisions of State AIDS Control Societies shall work together to scale up services through mainstreaming especially through National Health Mission. Technical Support Unit may work out a mainstreaming plan in consultation with various divisions at State AIDS Control Societies and National AIDS Control Organisation so that the same can be implemented by various divisions at State AIDS Control Societies.

### **The Technical Support Unit :**

This is a State level technical support structure that is responsible for providing technical support to Targeted Interventions programme and Link Workers Scheme. The Technical Support Unit provides strategic and implementation support in four key areas:

- i. Support in development of improving the evidence building and approaches in line with National Guidelines.
- ii. Support in development of training curricula aligned to the Guidelines.
- iii. Support in development of communication materials.
- iv. Support in building capacity of implementing partners in areas of programming, Monitoring and Evaluation.

### **District AIDS Prevention & Control Units:**

District AIDS Prevention & Control Units being important coordinating body at selected Districts will carry out following functions for strengthening the implementation of the Link Worker Scheme:

- i. Conduct monthly review meeting of District level Non-Governmental Organisation ensuring that issues related to service availability, availability of condoms or needles and syringes or Information, Education and Communication or Behaviour Change Communication materials or support from Mobile Integrated Counselling and Testing Centre or Mobile medical units or support of Tuberculosis Bacili programme or support of Accredited Social Health Activist or Anganwadi workers or Auxiliary Nurse and Midwifery is facilitated by taking relevant issues with respective officers.
- ii. Ensure District level coordination among various agencies directly or indirectly linked to smooth implementation of Link Workers Scheme.
- iii. Data validation especially of referral services accessed by beneficiaries of Link Workers Scheme.
- iv. Shall not use cluster link workers for tracking of Loss to Follow ups in non-Link Workers Scheme villages
- v. Shall not use Cluster Link Workers to implement programmes which are not approved By State AIDS Control Societies.

**Implementing partners (Non-Governmental Organisations, Community Based Organisations):**

Implement and manage the interventions as per the requirement of National Guidelines and ensure there is no duplication of activities or funding resources for same activities.

**State Training and Resource Centres:**

The State Training and Resource Centres are expected to build capacity of the implementing partners, help in developing local level evidence for better programming, document best practices to improve quality of the programme.

**Private Health Care Providers:**

The Link Workers Scheme is expected to identify and collaborate with private health care providers that they are sensitised and trained on National Guidelines to provide necessary services for the target population. To establish, document and strengthen referral systems and quality of services.

**ANNEXURES**

**Annexure 1 (Format for line listing cum service tracking sheet)**

District \_\_\_\_\_

Block \_\_\_\_\_

Name of the link worker \_\_\_\_\_

Month: \_\_\_\_\_

Year: \_\_\_\_\_

Village name	Household No. /Name of the hotspot	Name of the person	Age	Sex( M/F /T)	Marital status (M- married, UM- Unmarried d, D- Divorced, S-Separate d)	Category *	Date of registration on as per the Guidelines	Date when services provided or accessed (Integrated Counselling and Testing Centre testing, Sexually Transmitted Infections clinic visit or treatment, Condoms provided)	Date when dropped out due to migration or services are completed as per the Guidelines	Services for which referral made	Referral Services accessed (yes or no), if yes write the name of the center	Whether the same person is receiving services from a Targeted Interventions or any other link worker village	Remarks (including dates for subsequent services)
								Integrated Counselling and Testing Centre	Sexually Transmitted Infections	Condom			

\* 1-Female Sex Workers,2-Men Who Have Sex with Men, 3-Injecting Drug User,4-Truckers,5-Tuberculosis Bacili patient,6-Pregnant mother,7-People Living with HIV,8-Children Living with HIV,9-Spouses of Female Sex Workers, 10-Spouse of Injecting Drug User, 11-Spouse of Men Who Have Sex with Men, 12-Spouse of Transgender, 13-Spouses of migrant, 14-Spouses of truckers. In case of above target population is not met with services for three months, the same may be dropped out for next quarter. Separate format for migrant linelisting.



## Annexure 2 (Line list format for migrants)

4	3	2	1	Sl. No.	Destination details
				State	
				District	
				Taluka / Thesil	
				Block	
				Post Office	
				Revenue Village	
				Segment Code	
				House street Colony code	
				Name of the breadwinner/Guardian/Head of the Family	
				Name of the Key Population	
				Unique ID	
				Sex	
				Age	
				Father's name	
				Whether eligible for Rashtriya Swasthya BimaYojana	
				Does he/she have the required docs to be registered with Rashtriya Swasthya Bima Yojana	
				Whether registered with Rashtriya Swasthya Bima Yojana	
				Spouse Name	
				Whether eligible for Janani Bal Suraksha Yojana	
				Whether linked with Janani Bal SurakshaYojana	
				Husband's name (for female migrants)	
				Category Code	
				Mob No.	
				State	
				District	
				Town	
				Post Office	
				Major Landmark (if any)	
				Occupation	
				Referred (HIV) Date	Services Delivery Status ofmigrant
				Tested (HIV) Date	
				HIV Status	
				Treated (Sexually Transmitted Infections) Date	
				Referred (Sexually Transmitted Infections) Date	
				Sexually Transmitted Infections Treatment for (Type)	
				Antiretroviral Treatment Linkage	
				District level Network Linkage	
				Referred for T.B.	
				Tuberculosis status	
				Duration of stay in source : No. of Days	
				Planning to go back to destination (Tentative date)	

## Annexure 3: Interpersonal Communication tools

### Name of the Tool: Body Mapping

**Objective of the tool:** To enable the participants to understand the risk and generate information on perceiving the risk level.

**User:** Cluster Link Workers

**What skills required by the facilitating team:** Knowledge about transmission modes, knowledge about risky behaviours, difference between risk and vulnerability, knowledge about risks associated with High Risk Groups, their partners and whether this has any impact on their risk perception levels.

**Materials required:** At least two chart paper and three to four colour markers for each session

Additional materials can be in the form of a flip chart with a story about the clients they come across, these clients being non-committal to any body in using condoms can carry HIV virus from one High Risk Group to another. Thus once the High Risk Group gets infected with Sexually Transmitted Infections or HIV it limits their ability to earn better and lead a quality of life.

**Degree of privacy:** Moderate

**Time required:** 30-45 minutes per session

### Method:

- (i) Collect at least 8-10 participants majority of them shall be from the target population.
- (ii) Ask one group to draw the outline of human body and ask other group to indicate what risk do they carry in each part of the body which is harmful to their life e.g. taking unhealthy food or water may affect their stomach, smoking can have cancer, unprotected sex can lead to Sexually Transmitted Infections or HIV etc.
- (iii) While one group starts calling out the risk behaviours, the other group shall write down them on another paper.
- (iv) Pick 3 risk behaviours (one must include risk behaviour associated with Sexually Transmitted Infections/HIV). Ask participants to build consensus on these.
- (v) Ask one group to write each of these risk behaviour and circle them. Ask now both groups to tell why these are risk behaviour and if so how can be prevented.
- (vi) Ask both groups to highlight the reasons in another chart paper, which can be controlled by individuals and which require support from peers, family and others.
- (vii) Conclude highlighting that better understanding of reasons and application of efforts can reduce any sort of risk include risk for Sexually Transmitted Infections or HIV.

Additionally, both groups can work out messages for their own groups which can be used for replication and messaging on various risk behaviours among the target population.

### Name of the Tool: Service Mapping

**Objective of the tool:** To enable the participants to get information about various services and their location.

**User:** Cluster Link Workers

**What skills required by the facilitating team:** Knowledge about different formal and informal services used by the target population in the project area which may include services for daily life (grocery, government paper work) or services for health care. How different providers behave and how the target population perceive and react to these.

**Materials required:** At least two chart paper and three to four colour markers for each session

Additional materials can be in the form list, service hours, cost of services and contact details of various health and HIV related services may be printed out in the form of small hand outs or in the form of posters.

**Degree of privacy:** Low

**Time required:** 30-45 minutes per session

**Method:**

- (i) Collect at least 8-10 participants majority of them shall be from the target population.
- (ii) Divide the participants into two groups and keep two persons to be facilitator and time keeper.
- (iii) Ask one group to draw the map of the village and nearby localities – start marking the services they seek on a day to day basis including health care and HIV related services.
- (iv) Ask other group to highlight the services provided by the health care providers in the form of following:
  - What services they seek?
  - How much it costs?
  - Whether they get benefit out of these services ?
  - What is the source of information about these services?
- (v) Pick 3service providers which attract lots of the target population. Ask participants to build consensus on these.
- (vi) Ask one group to write which are the factors that make services attractive:
  - The cost or distance or benefits or behaviour of the provider or less waiting time or confidentiality and so on.
- (vii) Ask both groups to rank these 3services indicating if the services needs to be better especially in the case of providing HIV or Sexually Transmitted Infections related services.
- (viii) Conclude asking both the groups saying that the services can only be improved if one there is participation of the target population in providing these useful suggestions to the Non-Governmental Organisations, to the staff of these centres.
- (ix) The same chart papers can be used time and again to assess the feedback on the services, participation level as well as what additional services required.

**Name of the Tool: Vulnerability Mapping**

**Objective of the tool:** To enable the participants to understand the measures which can reduce their vulnerability.

**User:** Cluster Link Workers

**What skills required by the facilitating team:** Knowledge about different situations and factors that increases risk of the target population and what can be done to reduce their risks.

**Materials required:** At least two chart paper and three to four colour markers for each session

Additional materials can be in the form a flip book having two stories one about a youth who survives by staying with his family in the village and the friend of the youth who travels to distances comes across many friends but have habits of consuming alcohol, gambling and often visiting sex workers.

**Degree of privacy:** Low

**Time required:** 30-45 minutes per session

**Method:**

- (i) Collect at least 8-10 participants majority of them shall be from the target population.
- (ii) Divide the participants into two groups and keep two persons to be facilitator and time keeper.
- (iii) Ask one group to write down if whether the youth who stays in village have the risk of having Sexually Transmitted Infections or HIV, if so why and how can be prevented.
- (iv) Same question can be put to the other group who is a family member of migrants or truckers.
- (v) Ask both groups to discuss what if can be done so that the migrants or truckers and his friend can make difference preventing both of them from Sexually Transmitted Infections or HIV. It does not necessarily that either of them leaves their occupation or exchange their occupation— it is that the person have to make informed choice for better life.
- (vi) Conclude asking both the groups saying that the being responsible to their life can bring changes both within the individual as well as among their peers.

New stories can be built up or the participants can be asked to tell stories about their life and different challenges they face.

[illegible]

**Annexure 5 (Referral and Linkage monitoring formats for Zonal supervisor)****Name of the Zonal Supervisor:****Name of the Village:****Name of the Block:****Name of the District:****Reporting Quarter:****Year:**

Category of persons	No. of persons reached Integrated Counselling and Testing Centre or Prevention of Parent to Child Transmission or testing done during health camps		No. of persons visited or treated with Sexually Transmitted Infections (both govt. and private)		No. of persons tested for syphilis		No. of persons received Antiretroviral Treatment services		No. of persons linked with People Living with HIV network		No. of persons linked with social benefits schemes		Any other services linked	
	T	A	T	A	T	A	T	A	T	A	T	A	T	A
Ante Natal mothers														
Spouses of Female Sex Workers														
Spouses of Men Who Have Sex with Men or Transgender														
Spouses of Injecting Drug User														
Spouses of migrants														
Spouses of truckers														
Female Sex Workers														
Men Who Have Sex with Men														
Injecting Drug User														
Transgender or Hijra														
Migrants														
Truckers														
Youth with Sexually Transmitted Infections or HIV or AIDS														
Children with HIV or AIDS														
Tuberculosis Bacili patients														
People Living with HIV														

T = Target for the quarter, A = Achievement during the quarter



**Annexure 6 (Stock and Issue register for Cluster Link Workers)**

Name of the Cluster Link Worker:

Name of the Block:

Name of the District:

Month of reporting:

Year:

S.No.	Name of the item	Source from where received	Opening balance of the item	Total numbers received during the month	Total Number of items available at the start of the month	Total numbers distributed or socially marketed during the month	Closing Balance of the item
1	2	3	4	5	6=(4+5)	7	8=(6-7)
	Free Condoms						
	Needles						
	Syringes						
	Socially marketed condoms						
	Information, Education and Communication materials						
	Behaviour Change Communication materials						

**Annexure 6a (Stock and Issue register for District level)**

Name of the reporting person with designation:

Name of the Block:

Name of the District:

Month of reporting:

Year:

S.No.	Name of the item	Source from where received	Opening balance of the item	Total numbers received during the month	Total number of items available at the start of The month	Total numbers issued during the month (mention date of issue)	Person to whom issued on the date mentioned in the earlier column	Signature of the person received or place the voucher number in case the item was sent through post/courier	Closing balance of the item
1	2	3	4	5	6=(4+5)	7			8=(6-7)
	Free Condoms								
	Needles								
	Syringes								
	Socially marketed condoms								
	Information, Education and Communication materials								
	Behaviour Change Communication materials								

Indenting Format (to be signed by the District Resource Persons only, should be on the letterhead of the organisation along with copy of the sanction letter or office order of State AIDS Control Societies indicating that the agency is expected to receive items from the concerned authority)

Designation of the officer to whom addressed (Medical Officer or Auxiliary Nurse and Midwifery or Joint Director of State AIDS Control Societies)

Number of items for which indent placed	Number of items earmarked for the programme at the start of the year	Total items received till date	Remarks about last supply received

Purpose for which items received has been fulfilled: (Yes/No)

I certify that the items have been used for the purpose for which it was supplied for during the period from \_\_\_\_\_ to \_\_\_\_\_ by \_\_\_\_\_ organisation.

(Signature)

(Please retain a copy with the organisation and share a copy with State AIDS Control Societies in case the intended supply is to be done by Block or District or State level organisation other than State AIDS Control Societies)

**Annexure 7: (Visit report)** for District Resource Persons, senior staff of implementing agency

Date of visit: DD/MM/YYYY

Name of the reporting person:

Places of visit:

Designation of the reporting person:

Purpose of the visit:

- 1.
- 2.
- 3.

Persons met during the visit:

Summary of discussions or observations:

Action taken and future action plan:

Observations	Action taken	Future action plan	Responsibilities	Timeline

(The report should not be more than two pages and should be signed by all concerned as well as the reporting officer)

**Annexure 8 (Meeting activities register)** for various meetings such as stakeholders, meeting with health department/women and child development department, District officers, internal meetings

Name of the Block:

Name of the District:

Month of reporting:

Year:

Date of the meeting held:

Purpose of the meeting:

Name of the persons who attended the meeting	Designation of the persons	Decisions taken	Next plan of action	Responsibilities	Expected timeline by which the discussed activities is expected to commence	Expected timeline by which the Discussed activities is Expected To complete	Any other
1	2	3	4	5	6	7	8

**Annexure 9: Recruitment Process:**

Position	Qualification and Experience	Recruitment Process	Agencies required
District Resource Person	<p>Masters in Social Sciences with at least three years experience in working with programmes related to livelihood promotion, adult literacy, microfinance, health sector programmes not merely awareness activities.</p> <p>Shall be based in the District for which applied.</p> <p>Shall be willing to travel in the District extensively. Shall have knowledge of MS-Word, Excel.</p>	<p>Open advertisement followed by written test and interview.</p> <p>Written test questions to be provided by the Joint Director or Deputy Director or Assistant Director Targeted Interventions or Link Workers Scheme.</p> <p>The interview panel should have representation from State AIDS Control Societies or Technical Support Unit, District officers from District AIDS Prevention &amp; Control Unit or District Nodal Officer on HIV or AIDS.</p>	<p>District Implementing Agency</p> <p>State AIDS Control Societies</p> <p>Technical Support Unit</p> <p>District AIDS Prevention &amp; Control Unit</p> <p>District Nodal Officer on HIV or AIDS</p>
Zonal Supervisor	<p>Bachelors in Social Sciences with at least two years experience in working with programmes related to livelihood promotion, adult literacy, microfinance, health sector programmes not merely awareness activities.</p> <p>Shall be based in the District for which applied.</p> <p>Shall be willing to travel in the District extensively. Shall have a vehicle for travel.</p> <p>Shall have knowledge of MS-Word, Excel.</p>	<p>Open advertisement followed by interview</p> <p>The interview panel should have representation from District officers from District AIDS Prevention &amp; Control Unit or District Nodal Officer on HIV or AIDS.</p>	<p>District Implementing Agency</p> <p>District AIDS Prevention &amp; Control Unit District Nodal Officer on HIV or AIDS</p>
Cluster Link Workers	<p>10+2 or above with at least one year experience in working with programmes related to HIV or Health or Livelihood promotion, adult literacy, microfinance, health sector programmes not merely Awareness activities.</p> <p>Existing link workers who fulfill above criteria will be considered as priority.</p> <p>Shall be based in the District for which applied. Shall be willing to travel in the District extensively.</p> <p>Preference should be given to candidates having a vehicle for travel.</p>	<p>Open advertisement followed by interview</p> <p>The interview panel should have representation from District officers from District AIDS Prevention &amp; Control Unit or District Nodal Officer on HIV or AIDS or Block level Programme manager</p>	<p>District Implementing Agency</p> <p>District AIDS Prevention &amp; Control Unit District Nodal Officer on HIV or AIDS</p>



Position	Qualification and Experience	Recruitment Process	Agencies required
Monitoring and Evaluation officer cum Accounts Assistant	Bachelor in Commerce or Computer Application with atleast 1 year experience in managing data, data entry, creating analysis sheets from excel, preparing power point presentations. Experience of managing accounts for any Non-Governmental Organisation would be preferred.	Open advertisement followed by interview The interview panel should have representation from district officers from District AIDS Prevention & Control Unit or District Nodal Officer on HIV or AIDS or Block level Programme manager	District Implementing Agency District AIDS Prevention & Control Unit District Nodal Officer on HIV or AIDS

### Annexure 10 (Human Resources) to be filled by District Resource Persons

Name of the District:

Reporting Month:

Year:

Category of staff	Total no. of staff during last month		Total no. of staff joined during reporting month		Total no. of staff available at the end of reporting month		No. of staff Completed training by Non-Governmental Organisation		No. of staff Completed training by State Training and Resource Centres or State AIDS Control Societies or any other agencies		Write down the topics or areas trained so far			
	S	A	S	A	S	A	S	A	S	A	1	2	3	4
District Resource Persons														
Zonal Supervisor														
Zonal Supervisor														
Monitoring and Evaluation cum Accounts Assistant														
Cluster Link Workers														

S = Sanctioned, A = Available

### Annexure 11 (Monthly Reporting Format)

The soft copies of these formats would be available with State AIDS Control Societies

[illegible]



3. Linkages and utilisation of services							
	Total new identified during the month	Total referred during the month	Tested / Treated during the month	Cumulative accessing services till the month			
a. Tuberculosis Bacilli referrals (DMC center)							
b. Only for High Risk Group population							
c. People Living with AIDS network							
d. No. identified positive							
e. Sexually Transmitted Infections/ Reproductive Tract Infections cases							
e. Antiretroviral Treatment referral							
4. Outreach activities:							
	Total no.	Cumulative no.	Date	Objectives	Key Outcomes	No. of person participated	
a. Advocacy meeting with District level stakeholders							
b. Meetings with other village functionaries (Panchayat/Nehru Aadarsh Kendra Sangathan etc)							
c. Community events and meetings organised with Self Help Group/Youth clubs							
d. Others (Specify)							
5. Financial Status	Budget Approved for the FY			Expenditure made till reporting month		SOE submitted till date	
6. Major Highlights (if any)- annex the detail reports of the events							
7. Activities planned for next month:							

### Reporting Requirements:

As per the requirement of the Link Workers Scheme, the following reporting requirements are mandatory. The backup of various information below will follow National AIDS Control Organisation's and Government of India's Intellectual Property Rights. None of these information can be used for purposes otherwise agreed in the contract. Upon requirement, all these information shall be shared with State AIDS Control Societies.

Name of the report	Soft Copy and Back up	Hard Copy
Line listing cum service tracking format except for migrants	Yes	Yes
Line listing of migrants	Yes	Yes
Referral and Linkage register	No	Yes
Referral and linkage monitoring format	No	Yes
Stock and Issue	Yes	Yes
Stock and Issue at District level	Yes	Yes
Field visit report	No	Yes
Meeting register	No	Yes
Recruitment Process	No	Yes
Human Resources	Yes	Yes
Accounts and Finance	Yes	Yes
Monthly report	Yes	Yes
Monthly analysis report for each Supervisor	Yes	Yes

### Data definitions:

**Item: Monthly Reporting format**

**Who fills: Monitoring and Evaluation cum Accounts**

**Frequency: Monthly**

### Purpose of the report:

- To report the key indicators of the programme implemented by the District during the last reporting month.

**Explanations:**

Name	Explanation	Source of collection
Name of the District	District in which the programme is being implemented	Self explanatory
Contact number		Self explanatory
Name & Designation of the reporting officer	Person reporting on behalf of the implementing Non-Governmental Organisation	Self explanatory
Month	Last month of implementation	
Year	Current year of implementation	
State	State in which the programme is being implemented	
No. of Blocks under Implementation	This may differ from the no. of Blocks reporting as some Blocks might have not been included for activities during last month	
No. of Blocks reporting	No. of Blocks reporting during the last reporting month	
No. of villages under implementation during the month	Write the no. of villages implemented the programme in each Block during last month	Cluster Link Workers and supervisor daily report
No. of estimated High Risk Groups targeted during the start of the quarter	Write the no. of estimated High Risk Groups targeted in the villages during start of the quarter – this may be the Situation Need Assessment information, may be the line listed figures available with each Cluster Link Worker	Situation Need Assessment information Line listed minus drop outs for each Cluster Link Worker
No. of High Risk Groups contacted during the month	Write the no. of High Risk Groups contacted during the month	Cluster Link Worker's Interpersonal Communication contact information and the No. of Interpersonal Communication sheets submitted by Cluster Link Workers
No. of High Risk Groups provided commodities during the month	Write the no. of High Risk Groups provided condoms or needles and syringes – as in the line listing sheet reported during last month	Cluster Link Workers line listing sheet indicating no. of condoms or needles and Syringes distributed



Name	Explanation	Source of collection
No. of High Risk Groups underwent HIV testing and counselling during the month	Write the no. of High Risk Groups who underwent HIV testing during the last reporting month	Line listing information sheet and referral slips signed by concerned Integrated Counselling and Testing Centre staff
No. of vulnerable population underwent HIV testing and counselling	Write the No. of vulnerable population who underwent HIV testing during the last reporting month	Line-listing information sheet and referral slips signed by concerned Integrated Counselling and Testing Centre staff
No. of High Risk Groups and vulnerable population tested positive during the month	Write the no. of new HIV positives detected from amongst the referred cases	Referral slips signed by concerned Integrated Counselling and Testing Centre staff
No. of High Risk Groups and vulnerable population inked to pre-Antiretroviral Treatment or Antiretroviral Treatment programme	Write the no. of new and old cases (detected positives) were linked to pre-Antiretroviral Treatment or Antiretroviral Treatment	Referral register verified by Antiretroviral Treatment clinic staffs
Total no. of Sexually Transmitted Infections cases treated during the month	Write the no. of new and old Sexually Transmitted Infections cases treated during the month	Line listing cum service record of Cluster Link Workers
No. of activities conducted	Write the no. of various activities carried out during the month and number of different beneficiaries covered by these activities	One to one, one to group, mid-media, health camp, meeting registers to be used to report these activities. Use unique individuals data to report from various other registers.
Total no. of AN mothers received any services	The unique individual Antenatal Care mothers receiving any of the services – one Antenatal Care mother may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of Tuberculosis Bacili patients received any services	The unique individual Tuberculosis Bacili patients receiving any of the services – one client may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of Female Sex Workers (high and medium volume)	The unique individual Female Sex Workers receiving any of the services – one client may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of Men Who Have Sex with Men or Male Sex Workers	The unique individual Men Who Have Sex with Men or Male Sex Workers receiving any of the services– one clients may receive threeservices – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers

Name	Explanation	Source of collection
Total no. of Injecting Drug Users	The unique individual Injecting Drug Users receiving any of the services – one client may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of migrants	The unique individual migrants receiving any of the services – one migrant may receive three services –but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of truckers	The unique individual truckers receiving any of the services – one trucker may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of spouses of vulnerable population	The unique individuals receiving any of the services – one may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers
Total no. of People Living with HIV/People Living with AIDS Total no. of Children Living with Human Immunodeficiency Virus	The unique individuals receiving any of the services – one may receive three services – but the number has to be reported for one service only The unique individuals receiving any of the services – one may receive three services – but the number has to be reported for one service only	Line listing cum service record of Cluster Link Workers Line listing cum service record of Cluster Link Workers
No. of one to one sessions conducted	Number of sessions conducted by the Cluster Link Workers	Cluster Link Workers information
No. of one to group sessions conducted	Number of sessions conducted by the Cluster Link Workers	Cluster Link Workers information
No. of mid-media campaigns held	Number of sessions conducted by the Cluster Link Workers	Cluster Link Workers information
No. of Village Health and Nutrition Day meetings attended by implementation team	Number of sessions conducted by the Cluster Link Workers	Cluster Link Workers information
No. of persons treated for HIV by different category	Referral register	Self explanatory
No. of Sexually Transmitted Infections treated by different category	Cluster Link Workers line listing cum service records	Self explanatory

Name	Explanation	Source of collection
Total no. of unique individuals reached with any services	Unique individuals are individuals from target population who have been provided services as per the Guidelines	Line listing format and service tracking, referral and linkage register.
No. of manpower approved	No. of staff approved in the budget or contract	
No. of manpower in place	No. of staffs in place during last month	
No. trained during the month	No. of available staff who are trained during last month	
Cumulative trained during the year	No. of staff trained till the reporting month	
No. of days visit made during the month by each staff	No. of days visit made by each staff during the reporting month	Field visit reports and field diaries to be cross checked
No. of meetings with other stakeholders held	No. of meetings held by the staff during the reporting month	Meeting reports to be cross checked
No. of social marketing condom depots established	No. of depots established till the reporting month	
Uptake of condoms by social marketing	No. of condoms socially marketed by the available condom outlets during the reporting month	
Uptake of condoms through free distribution	No. of condoms distributed free by the staff	Line listing and service tracking format, stock and issue registers
No. of needles/syringes distributed	No. of needles or syringes distributed by the staff during the reporting month	Cluster Link Workers diary, linelisting and service record of Cluster Link Workers, stock and issue registers
No. of needles/syringes collected and sent for safe disposal	Number of needles or syringes collected from field by Cluster Link Workers or supervisors and sent for disposal	Biomedical waste management register
No. of Information, Education and Communication materials distributed	No. of Information, Education and Communication materials distributed by the staff	Stock and issue registers and Cluster Link Workers daily diaries
No. of Behaviour Change Communication materials distributed	No. of Behaviour Change Communication materials distributed by the staff	Stock and issue registers and Cluster Link Workers daily diaries
Volunteers in place, trained and cumulative trained	No. of volunteers contacted, trained during the reporting month	
Total new identified	Individuals who received various services in Tuberculosis Bacili, Antiretroviral Treatment and Sexually Transmitted Infections treatment first time by the project. This may also include High Risk Groups, persons linked with	Line-listing register, referral and linkage register

People Living with AIDS network		
Name	Explanation	Source of collection
Total referred during the month or Tested or treated during the month	Individuals who received various services in Tuberculosis Bacili, Antiretroviral Treatment and Sexually Transmitted Infections treatment first time by the project. This may also include High Risk Groups, persons linked with People Living with AIDS network	Line-listing register, referral and linkage register
Cumulative accessing services till the month	Cumulative of no. of tested or treated till the month of reporting	
Tuberculosis Bacili referrals or Only for High Risk Group population or People Living with AIDS network or No. of identified positive or Sexually Transmitted Infections or Reproductive Tract Infections cases or Antiretroviral Treatment referral	Self explanatory	
Advocacy meeting with District level stakeholders	Meeting with stakeholders	Meeting register
Meeting with other village functionaries (Panchayat or Nehru Aadarsh Kendra Sangathan etc.)	Meeting with these functionaries	Meeting register
Community events and meetings with Self Help Group or Youth clubs	Self explanatory (community events with any group of target population during Behaviour Change Communication sessions or health camps). Meetings with Self Help Group or Youth clubs self explanatory	Meeting register
Total no. or cumulative or date	Self explanatory, cumulative indicates the cumulative number of different activities carried out till the reporting month	Meeting register
Objectives or Key Outcomes or number of person participated Financial Status (Budget approved for the FY)	Objectives of the meeting or community events carried out, key outcomes including decisions and action outlines. Number of participated in the meeting or community events Budget approved for the FY in the project proposal	Meeting register Contract document and budget sheet
Financial Status (Expenditure made till the reporting month)	Cumulative figure from the Statement of Expenditure till the reporting month during the FY	Statement of Expenditure
Statement of Expenditure submitted till the date	Statement of Expenditure figure submitted till the date	Statement of Expenditure
Major Highlights	Describe major achievements	
Activities planned for next month	Describe major activities for next	

	month	
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**Item: Format for line listing Who fills: Cluster Link Worker**

**Frequency: As and when**

**Purpose of the line listing:**

- (i) To identify households by risk category, update their service requirements and service accessed.
- (ii) To monitor the progress of Cluster Link Workers scheme by villages and cluster of villages.
- (iii) To understand workload for a village or cluster of villages and help in optimising the requirements of Cluster Link Workers in a District irrespective of work load.
- (iv) To minimise duplication of services for High Risk Groups who are also line listed in a nearby village or nearby Targeted Interventions.

**Explanations:**

Name	Explanation	Source of collection
District	The name of the District for which the particular format is being filled	Project Proposal of the Link Workers Scheme
Block	The name of the Block for which the particular format is being filled	Project Proposal of the Link Workers Scheme
Name of the Cluster Link Worker	The name of the person who is responsible for filling the format	Self Explanatory
Village Name	The name of the village for which the particular format is being filled	Project proposal of the Link Workers Scheme
Household number	Household number as per the village	Self explanatory
	records for which the format is filled	
Name of the person	The name of the person who is line listed	Self explanatory
Age	The age of the person	Self explanatory
Marital Status	The marital status of the person	Self explanatory
Category (Female Sex Workers, Men Who Have Sex with Men, Injecting Drug User, Migrants, Truckers, Tuberculosis Bacilli patient, Pregnant mother, People Living with HIV, Children Living with HIV, Spouses of high risk groups or Bridge Population, youth, any other)	The category for which the person belongs to	As per the definition in the Guidelines
Date of registration as per the Guidelines	Date when the person is first time registered with the programme, also in case registered after dropping out	As per the definition in the Guidelines

Date when services provided or accessed (Integrated Counselling and Testing Centre testing, Sexually Transmitted Infections treatment, Condoms provided)	Date when the person accessed services and reported in the respective formats	As per the definition in the Guidelines
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Name	Explanation	Source of collection
Date when dropped out due to migration or services are completed as per the Guidelines	Date when the person could not be traced for services or was confirmed to have migrated or does not require services as per the Guidelines	As per the definition in the Guidelines
Services for which referral made	Report services for which referral was made with the service centres	As per the definition in the Guidelines
Referral Services accessed (yes or no)	Report services have been accessed for which referral was made	As per the definition in the Guidelines
Whether the same person is receiving services from a Targeted Interventions or any other Cluster Link Worker village	Report only cases where the same person has been recorded and receiving services from a nearest Targeted Interventions or Cluster Link Worker village	As per the definition in the Guidelines

**Item: Format for outreach planning**

**Who fills: Cluster Link Worker Frequency: As and when**

**Purpose of outreach planning:**

- (i) To use field level data related to availability of target population by their location and convenient timing for outreach activities.

**Explanations:**

Name	Explanation	Source of collection
Location	The place where an individual or a group of individuals from the target population can be met as per their convenience to provide information and/or services	Individuals or group of individuals as per their discussion during last meeting
Number of target population	The number of target population who have expressed their convenience for next meeting	Individuals or group of individuals
Timings	The time noted by individual or group of individuals for meeting or sharing information or providing Services	Individuals or group of individuals
Day	The day when meeting is planned as per the Convenience	Individuals or group of individuals

**Item: Format for stock and issue Who fills: Cluster Link Worker Frequency: Once a month**

**Purpose of documenting stock and issue of various items:**



- (i) To use data from stock and issue of various items handled by the Cluster Link Worker for improving the distribution of various commodities as per the need of target population

**Explanations:**

Name	Explanation	Source of collection
Name of the item	These items can be free or socially marketed condoms, needles, syringes, Information, Education and Communication or Behaviour Change Communication materials	Self explanatory
Source from where received	Mention from where the item has been received – it may be from Auxiliary Nurse and Midwifery, from District or Block Medical officer, Cluster Link supervisor or District Resource Persons	Self explanatory
Opening balance of the item	The number of items available at the start of every month or as per the date decided by State AIDS Control Societies or Non-Governmental Organisation	Based on calculation of items available at the start of the month and sum of items distributed during the month
Total numbers received during the month	The number of items received from various sources during the month	Self explanatory
Total number of items available at the start of the month	Sum of various items available at the start of the month plus the items received during the month	Calculation of items available at the start of the month and items received during the month
Total numbers distributed or socially marketed during the month	Sum of items distributed for various target population as mentioned in the line list. Sum of items socially marketed.	Information about distribution as per the line listing format and information on social marketing from the social marketing register
Closing balance of the item	The number of items available on the last day of the month or as per the date decided by State AIDS Control Societies or Non-Governmental Organisation	The calculation of total items available at the start of the month minus the sum of total items distributed or socially marketed during the month

**Item: Format for referral and linkage Who fills: Cluster Link Worker Frequency: As and when****Purpose of documenting referral and linkage activities:**

- (i) To use data monitoring of referrals and services accessed by various target population

**Explanations:**

Name	Explanation	Source of collection
Category of persons	Various target population	Self explanatory
No. of persons reached Integrated Counselling and Testing Centre or testing done during health camps	Total no. of persons as mentioned in the line list format who have accessed services at different referral centres	No. of persons who got tested for HIV amongst number of persons who were referred for HIV testing
No. of persons treated with Sexually Transmitted Infections (both govt. and private)		No. of persons who were treated for Sexually Transmitted Infections among those referred
No. of persons received		No. of persons who were receiving
Prevention of Parent to Child Transmission services		Prevention of Parent to Child Transmission services among those referred
No. of persons received Antiretroviral Treatment services		No. of persons who were receiving Antiretroviral Treatment services among those referred
No. of persons linked with People Living with HIV network		Number of persons who were linked to People Living with HIV network among those referred
No. of persons linked with social benefits schemes		No. of persons who were linked to social benefit schemes among those referred
Name	Explanation	Source of collection
Any other services linked	Any other services which were provided by the Non-Governmental Organisation or State AIDS Control Societies or any other institutions and the target population were linked with services.	Self explanatory

**Item: Format for documenting meetings Who fills: Member of Link Workers Scheme****Frequency: As and when****Purpose of documenting meeting activities:**

- (i) To document and use the proceedings of the meetings for improving the outcomes

**Explanations:** The items mentioned in this format are self explanatory and the information are to be collected from the respective meetings.

**Item: Format for referral and linkage monitoring Who fills: Zonal Supervisor**

**Frequency: Quarterly Once**

**Purpose of documenting referral and linkage monitoring activities:**

- (i) To use data monitoring of referrals and services accessed by various target population in each village in a quarter and understanding the barriers so that these issues can be addressed during stakeholder meetings.

**Explanations:** Self explanatory as mentioned in the format related to referral and linkage activities

**Item: Format for Human Resources Who fills: Frequency: Monthly Once District Resource Persons**

**Purpose of documenting HR related activities:**

- (i) To document and use the data for understanding staff availability, trainings undergone and areas of training by various agencies including by the Non-Governmental Organisation.

**Explanations:** Self explanatory as mentioned in the format related to Human Resources related activities

**Item: Format for Visit Report Who fills: District Resource Persons or Zonal Supervisor**

**Frequency: As and when**

**Purpose of documenting field visit related activities:**

- (i) To document and use the information for monitoring of purpose of visit, action taken during the visit and future plans worked out – followed up following the visit

**Explanations:** Self explanatory as mentioned in the format related to field visit related activities

**Item: Format for Stock and Issue register at District level Who fills: District Resource Persons**

**Frequency: As and when**

**Purpose of documenting stock and issue register at District level:**

- (i) To document and use the information stock and issue of various items for monitoring the inflow and out flow at District level.
- (ii) Ensure indenting at least when the stock level is less than three months for items
- (iii) Indenting format has been included to ensure smooth handling of supplies and maintain official records of indenting

**Explanations:** Self explanatory as mentioned in the format related to field visit related activities.

**संस्कृति मंत्रालय**

नई दिल्ली, 3 जुलाई, 2020

**का.आ. 685.**— केंद्र सरकार, राजभाषा (संघ के शासकीय प्रयोजनों के लिए प्रयोग) नियम, 1976 के नियम 10 के उप नियम 4 के अनुसरण में संस्कृति मंत्रालय के अंतर्गत आने वाले कार्यालय, राष्ट्रीय विज्ञान संग्रहालय परिषद की अधीनस्थ इकाई, आंचलिक विज्ञान नगरी लखनऊ-226024 जिसमें 80 प्रतिशत या इससे अधिक अधिकारियों/कर्मचारियों ने हिंदी का कार्यसाधक ज्ञान प्राप्त कर लिया है, को अधिसूचित करती है।

यह अधिसूचना राजपत्र में प्रकाशन की तारीख से प्रवृत्त होगी।

[फा. सं. 13016/1/2019-हिंदी]

वेदान्तम गिरी, संयुक्त सचिव

**MINISTRY OF CULTURE**

New Delhi, the 3rd July, 2020

**S.O. 685.**— In pursuance of Sub-rule (4) of Rule 10 of the Official Language (Use for official purposes of the Union) Rules, 1976, the Central Govt. hereby notifies Regional Science city, Lucknow-226024 the unit of National Council of Science Museums, under Ministry of Culture wherein 80% or more officers/staff have acquired working knowledge of Hindi.

This notification shall come into force from the date of publication in the Official Gazette.

[F. No. 13016/1/2019-Hindi]

VEDANTAM GIRI, Jt. Secy.

**पेट्रोलियम और प्राकृतिक गैस मंत्रालय**

नई दिल्ली, 3 अगस्त, 2020

**का.आ. 686 .**—केन्द्रीय सरकार, पेट्रोलियम और खनिज पाइपलाइन (भूमि में उपयोग के अधिकारके अर्जन) अधिनियम, 1962 (1962 का 50) की धारा 2 के खण्ड (क) के अनुसरण में और पेट्रोलियम एवं प्राकृतिक गैस मंत्रालय, भारत सरकार के का. आ. 101 दिनांक 17 जनवरी 2020, की अधिसूचना के संशोधन में उक्त अधिनियम के अधीन राजस्थान राज्य के राज्यक्षेत्र के भीतर हिन्दुस्तान पेट्रोलियम कॉर्पोरेशन लिमिटेड की मुंद्रा दिल्ली पाइपलाइन, आवा-सालावास पाइपलाइन और रेवाड़ी-कानपुर पाइपलाइन परियोजना के लिए सक्षम अधिकारी के कार्यों का निर्वहन करने के लिए श्रीमति नीतू बारूपाल, आर.ए.एस., राजस्थान सरकार को प्राधिकृत करती है। यह अधिसूचना की तारीख से लागू होता है।

[फा. सं. आर-11025(15)/5/2019-ओआर-I/ई-30377]

पी. सोमाकुमार, अवर सचिव

**MINISTRY OF PETROLEUM AND NATURAL GAS**

New Delhi, 3rd August, 2020

**S. O. 686.**—In pursuance of clause (a) of section 2 of the Petroleum Minerals Pipelines (Acquisition of Right of User in Land) Act, 1962 (50 of 1962) and in modification of Notification of the Government of India in Ministry of Petroleum and Natural Gas S.O. No. 101 dated the 17<sup>th</sup> January 2020, the Central Government hereby authorizes Smt. Neetu Barupal, RAS, Government of Rajasthan to perform the functions of Competent Authority for HPCL's Mundra Delhi Pipeline, Awa Salawas Pipeline and Rewari Kanpur Pipeline under the said Act, within the territory of Rajasthan State. This is applicable from the date of notification.

[F. No. R-11025(15)/5/2019-OR-I/E-30377]

P. SOMAKUMAR, Under Secy.

**कोयला मंत्रालय**

नई दिल्ली, 18 अगस्त, 2020

**का.आ. 687.**—केन्द्रीय सरकार को यह प्रतीत होता है कि, इससे उपाबद्ध अनुसूची में उल्लिखित परिक्षेत्र की भूमि में से कोयला अभिप्राप्त किए जाने की संभावना है;

अतः, उक्त अनुसूची में वर्णित क्षेत्र में अंतर्विष्ट ब्योरे योजनवहन संख्या एपीएमडीसी/मदनपुर/सीबीए/प्लान संख्या 1, तारीख 27 अप्रैल, 2020, का निरीक्षण, मुख्य महाप्रबंधक ( खोज प्रभाग), सेंट्रल माइन प्लानिंग एण्ड डिजाइन इन्स्टीच्यूट लिमिटेड, गोंडवाना पैलेस, कांके रोड, रांची (झारखंड) के कार्यालय में या कार्यपालक निदेशक/महाप्रबंधक- वित्त/मुख्य महाप्रबंधक (कोयला), आंध्र प्रदेश मिनरल डेवलपमेंट कारपोरेशन लिमिटेड, 294/1डी, 100 फीट रोड, ताड़िगाडपा टू एनिकापाडू रोड, कनूर, विजयवाड़ा-521137, आंध्र प्रदेश या कोयला नियंत्रक, 1, काउंसिल हाउस स्ट्रीट, कोलकाता - 700 001 के कार्यालय में या जिला कलक्टर, जिला कोरबा, (छत्तीसगढ़) के कार्यालय में किया जा सकता है।

अतः, अब, केन्द्रीय सरकार, कोयला धारक क्षेत्र (अर्जन और विकास) अधिनियम, 1957 (1957 का 20) (जिसे इसमें इसके पश्चात् उक्त अधिनियम कहा गया है) की धारा 4 की उप-धारा (1) द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए, उस भूमि में कोयले का पूर्वक्षण करने के अपने आशय की सूचना देती है।

उक्त अनुसूची में वर्णित भूमि में हितबद्ध कोई व्यक्ति, -

- (i) संपूर्ण भूमि या उसके किसी भाग या ऐसी भूमि में या उसके ऊपर किसी अधिकार के अर्जन पर आक्षेप कर सकेगा ; अथवा
- (ii) उक्त अधिनियम की धारा 4 की उप-धारा (3) के अधीन की गयी किसी कार्यवाही से हुई या होने वाली संभावित किसी क्षति के लिए अधिनियम की धारा 6 के अधीन प्रतिकर का दावा कर सकेगा; अथवा
- (iii) उक्त अधिनियम की धारा (13) की उप-धारा (1) के अधीन पूर्वक्षण अनुज्ञप्तियों के प्रभावहीन होने के संबंध में या उक्त अधिनियम की धारा 13 की उप-धारा (4) के अधीन खनन पट्टे प्रभावहीन होने के लिए प्रतिकर का दावा कर सकेगा और उसे उक्त अधिनियम की धारा 13 की उपधारा (1) के खंड (i) से खंड (iv) में विनिर्दिष्ट मदों की बाबत उपगत व्यय को उपदर्शित करने के लिए भूमि से संबंधित सभी मानचित्रों, चार्टों और अन्य दस्तावेजों को परिदत्त कर सकेगा,

इस अधिसूचना के राजपत्र में प्रकाशन की तारीख से नब्बे दिन के भीतर, कार्यपालक निदेशक/महाप्रबंधक- वित्त/मुख्य महाप्रबंधक (कोयला), आंध्र प्रदेश मिनरल डेवलपमेंट कारपोरेशन लिमिटेड, 294/1डी, 100 फीट रोड, ताड़िगाडपा टू एनिकापाडू रोड, कनूर, विजयवाड़ा-521137, आंध्र प्रदेश को भेज सकेगा।

क्र.सं.	ग्राम का नाम	पटवारी हल्का संख्या	तहसील	जिला	क्षेत्र हेक्टेयर में (लगभग)	टिप्पणियां
1.	मोरगा	44	पोड़ीउपरोड़ा	कोरबा	0.384	भाग
2.	केतमा	45	पोड़ीउपरोड़ा	कोरबा	0.162	भाग

जोड़ : 0.546 हेक्टेयर (लगभग) या 1.349 एकड़ (लगभग)



**(घ) वन भूमि :**

क्र.सं.	वन का नाम	रेंज	प्रभाग	क्षेत्र हेक्टेयर में (लगभग)	टिप्पणियां
1.	मोरगा	केन्दई	कटघोरा	398.427	भाग
2.	केतमा	केन्दई	कटघोरा	104.432	भाग
जोड़ : 502.859 हेक्टेयर (लगभग) या 1242.565 एकड़ (लगभग)					

कुल योग : ( क + ख + ग + घ): 712.072 हेक्टेयर (लगभग)

या 1759.530 एकड़ (लगभग)

**सीमा-वर्णन:**

- (1) रेखा बिन्दु संख्या 6 से 8: रेखा बिन्दु संख्या 6 से प्रारंभ होती है, कोयला ब्लॉक के उत्तर-दक्षिण छोर से और बिसरार नाला में सम्मिलित होते हुए पहुंचती है और रेखा बिन्दु संख्या 8 (जोकि ब्लॉक का उत्तर-पूर्व छोर है) और इसमें संरक्षित वन उपखंड संख्या पी-372 और पी-368 है।
- (2) रेखा बिन्दु संख्या 8 से 10 : रेखा बिन्दु संख्या 8 से प्रारंभ होती है, कोयला ब्लॉक के उत्तर-पूर्व छोर से और बिसरार नाला में सम्मिलित होते हुए पहुंचती है और रेखा बिन्दु संख्या 10 (जोकि ब्लॉक का दक्षिण-पूर्व छोर है) और इसमें संरक्षित वन उपखंड संख्या पी-368 और पी-366 है।
- (3) रेखा बिन्दु संख्या 10 से प्रारंभ होती है, कोयला ब्लॉक के दक्षिण-पूर्व छोर से और मोरगा ग्राम से होकर पहुंचती है और बिन्दु संख्या 1 से होते हुए कोयला ब्लॉक का दक्षिण-पश्चिम छोर है।
- (4) रेखा बिन्दु संख्या 1 से 6 : रेखा बिन्दु संख्या 1 से प्रारंभ होती है, कोयला ब्लॉक के दक्षिण छोर से और मोरगा और केतमा से होकर पहुंचती है और बिन्दु संख्या 6 से होते हुए जोकि कोयला ब्लॉक का उत्तर-पश्चिम है।

[फा. सं. 43015/5/2020-एलए एण्ड आईआर]

मुकेश, अवर सचिव

**MINISTRY OF COAL**

New Delhi, the 18th August, 2020

**S.O. 687.**— Whereas, it appears to the Central Government that coal is likely to be obtained from the land in the locality mentioned in the Schedule annexed to this notification ;

And, whereas, the plan bearing number APMDC/Madanpur/CBA/Plan No.1, dated the 27<sup>th</sup> April, 2020, containing details of the area of land mentioned in the said Schedule may be inspected at the office of the Chief General Manager (Exploration Division), Central Mine Planning and Design institute Limited, Gondwana Place , Kanke Road, Ranchi (Jharkhand) or at office of the Executive Director/General Manager-Finance/Chief General Manager (Coal), Andhra Pradesh Mineral Development Corporation Limited, 294/1D,100 Feet Road, Tadigadapa to Enikepadu Road ,Kanur, Vijayawada – 521137, Andhra Pradesh or at the office of the Coal Controller, 1, Council House Street, Kolkata-700001 or at the office of the District Collector, District Korba (Chhattisgarh).

Now, therefore, in exercise of the powers conferred by sub-section (1) of section 4 of the Coal Bearing Areas ( Acquisition and Development ) Act, 1957 (20 of 1957 ) , ( hereinafter referred to as the said Act ), the Central Government hereby gives notice of its intention to prospect for coal from the land described in the said Schedule.

Any person interested in the land described in the said Schedule may, —

- (i) object to the acquisition of the whole or any part of the land or of any rights in or over such land; or
- (ii) claim compensation under section 6 of the said Act for any damage caused or likely to be caused by any action taken under sub-section (3) of section 4 of the said Act ; or
- (iii) claim compensation under sub-section (1) of section 13 of the said Act in respect of prospecting license ceasing to have effect or under sub-section (4) of section 13 of the said Act for mining lease ceasing to have effect and deliver all maps, charts and other documents relating to the aforesaid land to show the expenditure incurred in respect of items specified in clauses (i) to (iv) of sub-section (1) of section 13 of the said Act.

to the office of the Executive Director/General Manager - Finance/ Chief General Manager (Coal), Andhra Pradesh Mineral Development Corporation Limited, 294/1D,100 Feet Road, Tadigadapa to Enikepadu Road, Kanur, Vijayawada – 521137, Andhra Pradesh within a period of ninety days from the date of publication of this notification.

## SCHEDULE

The Andhra Pradesh Mineral Development Corporation Limited

### Madanpur South Coal Block

Tehsil – Podiuproda

District Korba, State Chhattisgarh

[ Plan bearing number APMDC/Madanpur/CBA/Plan No.1, dated the 27<sup>th</sup> April, 2020 ]

**(A) Private Land:**

[illegible]

**(B) Revenue Forest Land:**

Sr. No.	Name of Village	Patwari Halka number	Tehsil	District	Area in hectares (approximately)	Remarks
1.	Morga	44	Podiuproda	Korba	0.067	Part
2.	Ketma	45	Podiuproda	Korba	145.675	Part
<b>Total : 145.742 hectares(approximately) or 360.128 acres (approximately)</b>						

**(C) Government Land:**

Sr. No.	Name of Village	Patwari Halka number	Tehsil	District	Area in hectares (approximately)	Remarks
1.	Morga	44	Podiuproda	Korba	0.384	Part
2.	Ketma	45	Podiuproda	Korba	0.162	Part
<b>Total : 0.546 hectares(approximately) or 1.349 acres (approximately)</b>						

**(D) Forest Land:**

Sr. No.	Name of Forest	Range	Division	Area in hectares (approximately)	Remarks
1.	Morga	Kendai	Katghora	398.427	Part
2.	Ketma	Kendai	Katghora	104.432	Part
Total : 502.859 hectares(approximately) or 1242.565 acres (approximately)					

Grand Total (A+B+C+D): 712.072 hectares (approximately)

or 1759.530 acres (approximately)

**Boundary Description:**

- (1) Line from point no. 6 –8. The line start from point no. 6 in north west corner of the coal block and follow the alignment all along Bissar Nalah and reaches point no. 8 (north east corner of the block) mainly intersect Protected Forest Compartment numbers P 372 and P 368.
- (2) Line from point no.8 to 10. The line start at point no. 8 in the north east corner and follow the alignment all along Bissar Nala and reaches point no. 10 (south east corner of the coal block) and intersect Protected Forest Compartment no. P 368 and P 366.
- (3) Line from point no. 10 in the south east corner of the coal block and passing through the Morga village and reaches point no. 1 which is south west corner of the coal block.
- (4) Line from point no. 1 to 6. The line starts from point no. 1 in the South west corner of the coal block and passing through Morga and Ketma village and reached point no. 6 north west of the coal block.

[F. No. 43015/5/2020-LA&IR]

MUKESH, Under Secy.

**श्रम एवं रोजगार मंत्रालय**

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 688.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स आर.के. मार्बल के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में औद्योगिक अधिकरण/श्रम न्यायालय, उदयपुर के पंचाट (संदर्भ संख्या 04/2015) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. जेड-16025/4/2020-आईआर(एम)]

ए. के. सिंह, अवर सचिव

**MINISTRY OF LABOUR AND EMPLOYMENT**

New Delhi, the 11th August, 2020

**S. O. 688.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 04/2015) of the Industrial Tribunal/Labour Court, Udaipur now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s R.K. Marble, and their workman, which was received by the Central Government on 05.08.2020.

[No. Z-16025/4/2020-IR(M)]

A. K. SINGH, Under Secy.

**अनुबंध****औद्योगिक विवाद अधिकरण एवं श्रम न्यायालय, उदयपुर****प्रकरण संख्या 04 सन् 2015 I.T.R.(C)**

श्री मुकेश राव बनाम श्री महाप्रबन्धक, आर.के. मार्बल

**14.12.2019**

प्रार्थी मुकेश राव मय अधिवक्ता श्री सुभाष श्रीमाली व विपक्षी प्रबन्धक की ओर से श्री अचलसिंह मैनेजर एच आर. मय अधिवक्ता श्री मोहम्मद शरीफ छीपा ने एक प्रार्थना पत्र पेश कर निवेदन किया कि प्रार्थी व विपक्षी के मध्य लोक अदालत की भावना से राजीनामा हो गया है तथा राजीनामा के अनुसार प्रार्थी को सब मिला कर कुल 75000/- रुपये अदा करने हेतु विपक्षी तैयार है जो राशि विपक्षी एक माह में अदा कर देगा, यदि एक माह में उक्त राशि अदा नहीं करेगा तो 12 प्रतिशत ब्याज देय होगा। इसलिये राजीनामा स्वीकार किया जावे व पत्रावली फैसल कराई जावे।

दोनों पक्षों को राजीनामा पढ़ कर सुनाया व समझाया गया तो दोनों पक्षों ने राजीनामा सही होना स्वीकार किया। जिस पर राजीनामा तस्दीक किया गया।

दोनों पक्षों में राजीनामा हो जाने से अब कोई विवाद शेष नहीं रहा है।

प्रार्थना पत्र संलग्न पत्रावली रहे।

इसलिये इस प्रकरण में No Dispute Award जारी किया जाता है।

पंचाट प्रकाशनार्थ समुचित सरकार को (सुलह अधिकारी एवं क्षेत्रीय श्रम आयुक्त {केन्द्रीय} अजमेर के पत्र क्रमांक ऐज-5(67)2014-आरएलसी दिनांक 06 मार्च, 2014 के क्रम में) भेजा जावे।

पत्रावली फैसल शुमार होकर दाखिल दफ्तर हो।

अरुण कुमार दूबे, अध्यक्ष

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 689 .—**औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स जे.के. अरोड़ा मार्बल प्रा0 लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में औद्योगिक अधिकरण/श्रम न्यायालय, उदयपुर के पंचाट (संदर्भ संख्या 03/2015) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. जेड-16025/4/2020-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 689.—**In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 03/2015) of the Industrial Tribunal/Labour Court, Udaipur now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. J. K. Arora Marble Pvt. Ltd., and their workman, which was received by the Central Government on 05.08.2020.

[No. Z-16025/4/2020-IR(M)]

A. K. SINGH, Under Secy.

**अनुबंध****औद्योगिक विवाद अधिकरण एवं श्रम न्यायालय, उदयपुर (राजस्थान)**

पीठासीन अधिकारी — श्री अरुण कुमार दूबे

**प्रकरण संख्या 03 / 2015 I.T.R.(c)**

श्री नारायणलाल पिता लिम्बाराम जाति मीणा  
निवासी मसारो की ओवरी फला मसीतली  
तहसील ऋषभदेव, जिला उदयपुर

...प्रार्थी

**विरुद्ध**

मेसर्स जे. के. अरोडा मार्बल प्रा. लि.  
मसारो की ओवरी, तहसील ऋषभदेव, जिला उदयपुर

...विपक्षी

**प्रार्थना पत्र धारा 2 (A)(2) औद्योगिक विवाद अधिनियम****उपस्थित :-**

प्रार्थी की ओर से : कोई उपस्थित नहीं।  
विपक्षी की ओर से : श्री आर. एस. चौहान, अधिवक्ता

**:: पंचाट ::**

दिनांक 29 जनवरी, 2020

प्रार्थी नारायणलाल द्वारा अपनी सेवा मुक्ति बाबत सर्वप्रथम शिकायत प्रार्थना पत्र क्षेत्रीय श्रम आयुक्त (केन्द्रीय) अजमेर के यहां दिनांक 23.07.2014 को प्रस्तुत किया था, जिन्होंने अपने पत्र दिनांक 15 सितम्बर, 2014 द्वारा असफल वार्ता प्रतिवेदन The Secretary (Desk Officer) New Delhi को प्रेषित कर दिया, लेकिन काफी समय व्यतीत हो जाने के बावजूद भी भारत सरकार के श्रम विभाग नई दिल्ली से रेफरेंस प्राप्त न होने पर प्रार्थी द्वारा यह क्लेम पेश किया है। जिस पर न्यायालय द्वारा प्रकरण दर्ज रजिस्टर किया गया एवं विपक्षीगण को नोटिस जारी किये गये।

प्रार्थी की ओर से प्रस्तुत क्लेम के तथ्य संक्षेप में इस प्रकार है कि प्रार्थी विपक्षी की खदान में दिनांक 01.03.2007 से कार्यरत है। प्रार्थी एवं विपक्षी के यहां कार्यरत अन्य श्रमिक दिनांक 23.01.2014 से 10 मई, 2014 तक हडताल पर थे। दिनांक 08 मई, 2014 को खान मालिको एवं श्रमिकों की यूनियन के मध्य एक समझौता हुआ था जिसके आधार पर सभी श्रमिकों ने 04.07.2014 से वापस काम पर जाने का निश्चय किया। दिनांक 04.07.2014 को प्रार्थी जब काम करने के लिए खदान पर गया तो उसे तथा अन्य श्रमिकों को काम पर लेने से इन्कार कर दिया और कहा कि तुम लोग यूनियनबाजी करते हो इसलिये तुम्हें काम पर नहीं रखेंगे। प्रार्थी को सेवा पृथक किये जाने का कोई कारण नहीं बताया तथा सेवा पृथक किये जाने से पूर्व उसे नोटिस या नोटिस-पे नहीं दी। प्रार्थी ने सेवा पृथक से पूर्व 9 वर्ष की सेवा पूर्ण कर ली थी। प्रार्थी ने वर्ष 2007 से 2014 तक प्रत्येक कलेण्डर वर्ष में 180 दिन से ज्यादा की सेवाएं दी हैं। इसके बावजूद भी प्रार्थी को बिना कानूनी प्रक्रिया अपनाये सेवा से पृथक कर दिया है जो पूर्णतया विधि विरुद्ध है। इसलिये दिनांक 04.07.2014 को की गई सेवा मुक्ति को अवैध घोषित किया जावे तथा प्रार्थी को विपक्षी के नियोजन में सेवा की निरन्तरता व अन्य लाभ के साथ पुनः सेवा में बहाल किये जाने का पंचाट पारित किया जावे।

विपक्षी को जबाब हेतु अनेको अवसर दिये गये, लेकिन विपक्षी की ओर से कोई जबाब पेश नहीं हुआ, इसलिये दिनांक 19.03.2019 को विपक्षी का जबाब बन्द किया गया।

प्रार्थी पक्ष को साक्ष्य प्रस्तुत करने हेतु कई अवसर दिये गये, लेकिन उसकी ओर से कोई साक्ष्य पेश नहीं हुई। विपक्षी ने भी कोई साक्ष्य पेश नहीं करना चाहा।

बहस अंतिम सुनी गई। पत्रावली का गहनता पूर्वक अवलोकन किया गया।

इस प्रकरण में इस न्यायालय द्वारा यह अभिनिर्धारित किया जाना है कि—“क्या प्रार्थी नारायण पिता लिम्बाराम मीणा निवासी मसारो की ओवरी को विपक्षी मेसर्स जे.के. अरोडा मार्बल प्रा. लि. द्वारा दिनांक 04.07.2014 को सेवा से पृथक किया जाना उचित एवं वैध है ? यदि नहीं, तो प्रार्थी क्या राहत पाने का अधिकारी है ?”

प्रार्थी ने न्यायालय में उपस्थित होकर विपक्षी के यहां कार्यरत रहना या विपक्षी द्वारा दिनांक 04.07.2014 को सेवा पृथक किये जाने के सम्बन्ध में कोई साक्ष्य या दस्तावेज पेश नहीं किया है।

अतः साक्ष्य के अभाव में विपक्षी द्वारा प्रार्थी को दिनांक 04.07.2014 को सेवा पृथक किये जाने का तथ्य साबित नहीं है। इसलिये प्रार्थी विपक्षी से कोई राहत पाने का अधिकारी नहीं है।

उक्त विवेचन के आधार पर पंचाट इस प्रकार पारित किया जाता है कि —

प्रार्थी नारायण पिता लिम्बाराम मीणा निवासी मसारो की ओवरी को विपक्षी मेसर्स जे. के. अरोडा मार्बल प्रा. लि. द्वारा दिनांक 04.07.2014 को सेवा से पृथक किये जाने का तथ्य साबित नहीं है।

अतः प्रार्थी नारायण मीणा कोई राहत पाने का अधिकारी नहीं है।

पंचाट प्रकाशनार्थ समुचित सरकार को क्षेत्रीय श्रम आयुक्त (केन्द्रीय) अजमेर के पत्र क्रमांक ऐजे. 5(108)/2014-आरएलसी दिनांक 15 सितम्बर, 2014 के क्रम में भेजा जावे।

अरुण कुमार दूबे, पीठासीन अधिकारी

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 690.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स सिद्धार्थ मार्बल प्रा. लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में औद्योगिक अधिकरण/श्रम न्यायालय, उदयपुर के पंचाट (संदर्भ संख्या 41/2015) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-28011/31/2015-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 690.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 41/2015) of the Industrial Tribunal/Labour Court, Udaipur now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Sidharth Marble Pvt. Ltd., and their workman, which was received by the Central Government on 05.08.2020.

[No. L-28011/31/2015-IR(M)]

A. K. SINGH, Under Secy.

### अनुबंध

### औद्योगिक विवाद अधिकरण एवं श्रम न्यायालय, उदयपुर (राजस्थान)

पीठासीन अधिकारी — श्री अरुण कुमार दुबे

### प्रकरण संख्या 41/2015 I.T.R.(C)

श्री अध्यक्ष, जनजाति खान मजदूर संघ,  
मसारो की ओवरी, तहसील ऋषभदेव, जिला उदयपुर

...प्रार्थी

### विरुद्ध

श्री मैनेजर, सिद्धार्थ मार्बल प्रा. लि.  
मसारो की ओवरी, जिला उदयपुर

...विपक्षी



**उपस्थित :-**

प्रार्थी की ओर से : श्री रमेश नन्दवाना, अधिवक्ता

विपक्षी की ओर से : श्री विजयकुमार ओस्तवाल, अधिवक्ता

**:: पंचाट ::**

दिनांक 11 फरवरी, 2020

भारत सरकार के श्रम विभाग की अधिसूचना क्रमांक L-28011/ 31/2015-IR{M} New Delhi दिनांक 22.06.2015 के द्वारा निम्नांकित विवाद इस न्यायालय को अधिनिर्णयार्थ प्रेषित किया गया –

“क्या यूनियन जनजाति खान मजदूर संघ, मसारो की ओवरी, ऋषभदेव जिला उदयपुर द्वारा प्रबन्धन के समक्ष उठायी गयी निम्नलिखित मांगे न्यायोचित है ? यदि हां तो श्रमिक किस राहत को पाने के अधिकारी है ?

- (1) 1 वर्ष में 12 दिन की छुट्टी— 26 जनवरी, 15 अगस्त, रक्षा बंधन, मकर संक्रान्ति, होली पर 4 दिन, दीपावली पर 4 दिन, 1 वर्ष में त्यौहारों पर 12 दिन छुट्टी देवे और 12 छुट्टी का पैसा देवें,
- (2) श्रमिकों को हाजरी कार्ड मय फर्म के साथ उपलब्ध करावे,
- (3) 250 हाजरी भरने पर पी.एल./सी.एल. की 18 छुट्टी का पैसा दिया जावे ।
- (4) 250 हाजरी भरने पर 12 प्रतिशत बोनस दिया जावे,
- (5) वर्ष में 2 जोड़ी जूते, कपड़े व सुरक्षा की सामग्री दी जावे,
- (6) मार्बल में ठेका प्रथा बन्द करे एवं सभी माईन्सों को कम्पनी के द्वारा चलाया जावे,
- (7) यूनियन द्वारा श्रमिकों के लिए वेतन दरों की मांग

क्र. सं.	केटेगरी	5 से 10 वर्ष के अनुभव पर (8 घंटे का वेतन)
1	मिस्त्री	700 रुपये
2	मशीन ऑपरेटर	700 रुपये
3	चेन सॉ ऑपरेटर	600 रुपये
4	सुपरवाइजर	500 रुपये
5	इलेक्ट्रीशियन	600 रुपये
6	वेल्डर	500 रुपये
7	डेरिक केन ऑपरेटर	500 रुपये
8	डम्पर ड्राइवर	400 रुपये
9	जे.सी.बी. ऑपरेटर	400 रुपये
10	वायर सॉ ऑपरेटर	500 रुपये
11	ऐल्टी फोर ऑपरेटर	450 रुपये
12	ड्रीलिंग ऑपरेटर	400 रुपये
13	स्टोर रूम	350 रुपये
14	चौकीदार	300 रुपये

उक्त आशय का प्रसंग प्राप्त होने पर न्यायालय द्वारा प्रकरण दर्ज किया जाकर सम्बन्धित पक्षकारान को नोटिस जारी किये गये। जिस पर प्रार्थी संघ की ओर से दिनांक 27.01.2017 को क्लेम किया गया था तथा विपक्षी की ओर से दिनांक 15.07.2019 को जबाब पेश किया गया।

प्रार्थी द्वारा प्रस्तुत क्लेम के तथ्य संक्षेप में इस प्रकार है कि— प्रार्थी यूनियन एवं विपक्षी के समक्ष पी.एफ. काटे जाने, छुट्टियों बाबत, हाजरी कार्ड उपलब्ध कराये जाने, पी.एल., बोनस आदि बाबत मांग पत्र रखा था जो मांगे अत्यन्त ही उचित एवं महत्वपूर्ण थी, लेकिन विपक्षी द्वारा इन मांगों को मांगने से इन्कार कर दिया। श्रमिक यूनियन द्वारा उठाई मांगे दिनांक 18.04.2013 को स्वीकार कर ली गई, लेकिन उसके बाद भी इन्हें लागू नहीं किया गया। इसलिये श्रमिक उक्त मांग पत्र की मांगों का लाभ दिनांक 18.04.2013 से प्राप्त करने के अधिकारी है। इसलिये केन्द्र सरकार से प्राप्त रेफरेन्स में वर्णित मांग पत्र मानने व तदनुसार भुगतान कराये जाने बाबत निर्णय पारित कराये जाने की प्रार्थना की।

विपक्षी ने अपने जबाब में यह प्रकट किया कि नियमानुसार लंच एवं साप्ताहिक छुट्टी दी जाती है, कम्पनी में नियुक्त कर्मचारियों का पी.एफ. काटा जाता है, त्यौहारों पर कर्मचारियों को छुट्टियां व बोनस आदि प्रदान किया जाता है, समय पर भुगतान किया जाता है, नियुक्त कर्मचारियों से आठ घंटे ही कार्य कराया जाता है, जो कर्मचारी नियुक्त है उन्हें सरकार द्वारा निर्धारित न्यूनतम वेतन के अनुसार भुगतान किया जाता है। इसलिये प्रार्थी यूनियन की ओर से प्रस्तुत क्लेम को खारिज किये जाने की प्रार्थना की।

प्रार्थी को साक्ष्य हेतु कई अवसर प्रदान किये गये, लेकिन प्रार्थी की ओर से कोई साक्ष्य पेश नहीं हुई। विपक्षी की ओर से भी कोई साक्ष्य पेश नहीं हुई।

उभय पक्षकारों की बहस सुनी गई। पत्रावली का अवलोकन किया गया।

प्रार्थी की ओर से अपने क्लेम के समर्थन में कोई मौखिक एवं दस्तावेजी साक्ष्य पेश नहीं हुई।

प्रार्थी पक्ष की ओर से कोई मौखिक एवं दस्तावेजी साक्ष्य पेश न होने से यह साबित नहीं होता है कि प्रार्थी यूनियन द्वारा विपक्षी संस्थान से किन्ही मांगों के सम्बन्ध में कोई मांग पत्र रखा और विपक्षी ने उन्हें स्वीकार नहीं किया हो। अतः साक्ष्य के अभाव में यह भी साबित नहीं होता है कि प्रार्थी यूनियन ने विपक्षी संस्थान के समक्ष मांगे उठाये हो और विपक्षी द्वारा उन्हें स्वीकार नहीं की हो।

उक्त विवेचन के आधार पर यह साबित नहीं होता है कि प्रार्थी यूनियन द्वारा विपक्षी संस्थान के समक्ष कोई मांग रखी हो और उन्हें विपक्षी द्वारा स्वीकार नहीं की हो। इसलिये प्रार्थी पक्ष कोई राहत पाने का अधिकारी नहीं है।

अतः भारत सरकार द्वारा प्रेषित प्रसंग दिनांक 22.06.2015 को उत्तरित करते हुए पंचाट इस प्रकार पारित किया जाता है कि—

प्रार्थी यूनियन जनजाति खान मजदूर संघ, मसारो की ओवरी, ऋषभदेव द्वारा विपक्षी संस्थान के समक्ष कोई मांग उठाया जाना व विपक्षी संस्थान द्वारा उन्हें स्वीकार नहीं किये जाने का कोई तथ्य साबित नहीं हुआ है।

अतः प्रार्थी पक्ष कोई राहत पाने का अधिकारी नहीं है।

पंचाट प्रकाशनार्थ समुचित सरकार को भेजा जावे।

अरुण कुमार दूबे, पीठासीन अधिकारी

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 691.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स राजस्थान स्टेट माईन्स एंड मिनरल्स लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में औद्योगिक अधिकरण/श्रम न्यायालय, उदयपुर के पंचाट (संदर्भ संख्या 08/2009) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-29012/6/2009-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 691.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 08/2009) of the Industrial Tribunal/Labour Court, Udaipur now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Rajasthan State Mines and Minerals Ltd., and other, and their workman, which was received by the Central Government on 05.08.2020.

[No. L-29012/6/2009-IR(M)]

A. K. SINGH, Under Secy.

**अनुबंध****औद्योगिक विवाद अधिकरण एवं श्रम न्यायालय, उदयपुर (राजस्थान)**

पीठासीन अधिकारी — श्री अरुण कुमार दुबे

**प्रकरण संख्या 08/2009 I.T.R.(C)**

श्री जनरल सेक्रेट्री,  
रॉक फॉस्फेट मजदूर संघ ( इंटक )  
झामर कोटडा, उदयपुर

...प्रार्थी

**विरुद्ध**

श्री मैनेजिंग डायरेक्टर,  
राजस्थान स्टेट माईन्स एण्ड मिनरल्स लि.  
झामरकोटडा खदान, उदयपुर

...विपक्षी

**उपस्थित :-**

प्रार्थी की ओर से : श्री सी. पी. शर्मा, अधिवक्ता  
विपक्षी की ओर से : श्री संजय सोनी, अधिवक्ता

**:: पंचाट ::**

दिनांक 29 नवम्बर, 2019

भारत सरकार के श्रम विभाग की अधिसूचना क्रमांक L29012/6/ 2009-IR{M} New Delhi दिनांक 28.05.2009 के द्वारा निम्नांकित विवाद इस न्यायालय को अधिनिर्णयार्थ प्रेषित किया गया —

“Whether the action of Management of General Manager, (Personal & Administration), Rajasthan State Mines and Minerals Ltd., Jhamar Kotda in imposing punishment by reducing the pay Scale of Shri Raghunath Singh Sakla S/o Late Shri Gowardhan Singh Sakhla Sr. Assistant Gr.I Stag Workman No. 16266 from 7400-200-9400-275-11600 to Rs. 6700-198-10660 vide their order dated 03/10/2007 is just and legal? What relief the workman is entitled to and from which date?”

उक्त आशय का प्रसंग प्राप्त होने पर न्यायालय द्वारा प्रकरण दर्ज रजिस्टर किया गया एवं सम्बन्धित पक्षकारान को नोटिस जारी किये गये। जिस पर प्रार्थी की ओर से क्लेम व विपक्षी की ओर से जबाब पेश किया गया।

प्रार्थी पक्ष द्वारा प्रस्तुत क्लेम के तथ्य संक्षेप में इस प्रकार हैं कि— प्रार्थी यूनियन विपक्षी संस्थान में कार्यरत श्रमिकों की एक मात्र प्रतिनिधि यूनियन है, जिसमें रघुनाथसिंह सांखला सचिव पद पर होकर वरिष्ठ नेता है। विपक्षी संस्थान में भारतीय जनता पार्टी समर्थित राजस्थान राज्य खान एवं खनिज मजदूर संघ की एक अल्पमत यूनियन है, जिसे विपक्षी संस्थान में बहुमत श्रमिकों का प्राप्त नहीं कर सकी, इसलिये प्रार्थी यूनियन के पदाधिकारियों को प्रताड़ित कर अपना प्रभाव जमाने के उद्देश्य से उनके द्वारा झूठी शिकायतें की गईं और विपक्षी प्रबन्धक द्वारा रघुनाथसिंह को दिनांक 22.04.06 को एक मिथ्या आरोप पत्र दिया जिसमें उस पर यह आरोप लगाया कि—“आपने अपने अन्य साथियों के साथ मिलकर श्री झामेश्वर श्रमिक ठेका सहकारी समिति नामक एक सहकारी संस्था का गठन किया, उसका पंजीयन करवाया तथा उक्त समिति द्वारा विपक्षी संस्थान द्वारा विभिन्न पार्टियों को विक्रय किये माल का अपने स्तर पर लदान आदि के कार्य करती है तथा आप संस्थान के स्थायी कर्मचारी होते हुए प्रबन्धन की पूर्व अनुमति के बिना ही उक्त समिति के सदस्य एवं पदाधिकारी बने व व्यवसायिक गतिविधियों में संलग्न रहे।” आपका उक्त कृत्य धारा 20 का स्पष्ट उल्लंघन है जो कि आदेश संख्या 21 ‘ए’ के अन्तर्गत दुराचरण माना गया है। इसके अतिरिक्त भी आपने स्थायी आदेशों के अनुच्छेद 21 के उप नियमों के तहत गम्भीर दुराचरण की परिभाषा में आते हैं जो कि आदेश संख्या 22—ए के तहत दण्डनीय है। जिस पर श्रमिक ने उक्त आरोपों को अस्वीकार करते हुए दिनांक 24.04.06 को अपना स्पष्टीकरण प्रस्तुत किया। विपक्षी द्वारा उक्त स्पष्टीकरण को सन्तोषजनक नहीं मानते हुए आदेश दिनांक 10.05.06 के द्वारा विभागीय जांच हेतु श्री सी.बी. राजन को जांच अधिकारी नियुक्त किया, जिन्होंने जांच कर रिपोर्ट प्रबन्धन को दिनांक 23.09.07 को प्रस्तुत की। जिस आधार पर विपक्षी द्वारा श्रमिक को दिनांक 03.10.2007 को वर्तमान वेतन श्रृंखला 7400—11600 से निम्न वेतन श्रृंखला 6700—198—10660 में पदावनत (Demote) किये जाने का दण्ड प्रस्तावित करते हुए नोटिस दिया जिसका श्रमिक ने दिनांक 09.10.2007 को प्रत्युत्तर दिया, परन्तु

उक्त प्रत्युत्तर को नजर अन्दाज करते हुए प्रस्तावित दण्ड को कन्फर्म किया। जांच कार्यवाही में जांच अधिकारी ने नैसर्गिक न्याय के सिद्धान्तों की अवहेलना की, आरोपित कर्मकार को अपने बचाव का युवितयुक्त अवसर नहीं दिया। जांच कार्यवाही में किसी भी गवाह ने यह नहीं कहा कि आरोपित कामगार ने कोई व्यक्तिगत लेनदेन किया हो या व्यवसायिक गतिविधियों में शामिल हो, कामगार श्रमिक ने उक्त समिति में अवैतनिक काम किया है, समिति का गठन मार्च 2004 में किया गया था और समिति ने प्लान्ट एवं स्लिपेज व अन्य कार्य हेतु निविदा भरी थी उस वक्त ही प्रबन्धन को पत्र दिनांक 24.03.04 द्वारा आरोपित कामगार ने सूचित कर दिया था कि परिशोधन संयंत्र में कार्यरत ठेका श्रमिक ने एक सहकारी समिति का गठन किया है व यह कार्य समिति को दिलाया जावे, जिस पत्र पर आरोपित कामगार के बतौर सचिव हस्ताक्षर थे व अन्य दस्तावेजों पर भी आरोपित कामगार के हस्ताक्षर हैं, परन्तु प्रबन्धन ने इस पर कभी भी एतराज नहीं किया। इस प्रकार आरोपित श्रमिक के विरुद्ध आरोप प्रमाणित नहीं थे, फिर भी जांच अधिकारी ने अनुचित निष्कर्ष निकाला। प्रार्थी यूनियन ने विपक्षी को उक्त एक तरफा जांच कार्यवाही के आधार पर की गई कार्यवाही को रोकने हेतु विपक्षी को दिनांक 17.10.07 को व्यक्ति रूप से मिलकर पत्र दिया व बाद में 11.03.08 को भी पत्र दिया लेकिन उक्त दण्ड को निरस्त नहीं किया गया। इसलिये प्रार्थना की है कि विपक्षी के आदेश दिनांक 10/11 अक्टूबर 2007 द्वारा वेतन श्रृंखला 7400-11600 से निम्न वेतन श्रृंखला 6700-10660 में पदावनत किये जाने के दण्ड को अनुचित एवं अवैध घोषित किया जावे तथा श्रमिक रघुनाथसिंह सांखला को दिनांक 10/11 अक्टूबर 2007 से ही पूर्व वेतन श्रृंखला में बहाल किया जावे व समस्त एरियर दिलाया जावे।

विपक्षी ने अपने जबाब में यह अंकित किया है कि विपक्षी द्वारा श्रमिक को गैर कानूनी व नाजायज कृत्यों की समस्त जांच करने पर पुख्ता प्रमाण होने से आरोप पत्र वास्तविक आधारों पर दिया गया था तथा श्रमिक द्वारा दिया गया स्पष्टीकरण सत्यता से परे होना पाया गया। प्रार्थी को सुनवाई का पर्याप्त अवसर दिया गया तथा जांच अधिकारी द्वारा नैसर्गिक न्याय के सिद्धान्तों की पूर्ण पालना की गई तथा उपलब्ध साक्ष्य, दस्तावेज आदि आधारों पर जांच रिपोर्ट दी गई थी। समिति का गठन प्रार्थी ने अपने निजी लाभ के लिये अपने साथियों से मिलकर किया व उसका पंजीयन करवाया। उक्त समिति का गठन 2004 में होने के तथ्य को भी गलत होना बताया। विपक्षी प्रबन्धन को समिति के गठन की कोई सूचना नहीं दी गई व नियमों के विपरीत आरोपित कामगार द्वारा समिति का गठन किया तथा वह सचिव पद पर वर्तमान में कार्यरत है। विपक्षी द्वारा इस तथ्य को अस्वीकार किया गया कि दण्ड दुर्भावना पूर्व शासक पार्टी द्वारा समर्पित यूनियन की मांग को पूरा करने के उद्देश्य से किया गया हो। प्रार्थी पक्ष की ओर से एक तरफा जांच कार्यवाही करना, अन्याय पूर्ण कार्यवाही करना, विपक्षी को पत्र देना, मांग पत्र देना आदि कथन गलत अंकित किये हैं। अतः प्रार्थी का क्लेम खारिज किये जाने की प्रार्थना की है।

प्रार्थी पक्ष की ओर से A.W-1 रघुनाथसिंह व A.W-2 एस.एम.अय्यर के शपथ पत्र प्रस्तुत किये जिनसे विपक्षी अधिवक्ता ने जिरह की एवं विपक्षी की ओर से N.A.W-1 डॉ. सुनिल सिंह दहिया व N.A.W-2 चेनालिट बालन राजन के शपथ पत्र प्रस्तुत हुए जिनसे प्रार्थी अधिवक्ता ने जिरह की। दोनों पक्षों की ओर से संबंधित दस्तावेज को प्रदर्शित कराया गया।

उभय पक्षकारान की मौखिक बहस सुनी गई। पत्रावली का गहनता पूर्वक अवलोकन किया गया।

विद्वान अधिवक्ता प्रार्थी का तर्क है कि इस प्रकरण में प्रार्थी को विपक्षी की ओर से कम्पनी के स्थायी आदेश की अवहेलना व दुराचरण बाबत आरोप पत्र देकर घरेलु जांच की गई तथा उसके आधार पर उसे पदावनत के दण्ड से दण्डित किया गया जो पूर्णतः अवैध व अनुचित है, क्योंकि घरेलु जांच में प्रार्थी को सुनवाई का अवसर नहीं दिया गया जो नैसर्गिक न्याय के सिद्धान्तों के विपरीत है, उसे साक्ष्य हेतु पर्याप्त अवसर नहीं दिया गया। इसके अलावा घरेलु जांच की पुष्टि में मौखिक एवं दस्तावेजी साक्ष्य प्रस्तुत नहीं हुई, किसी भी दस्तावेज को गवाह से साबित नहीं कराया गया, बल्कि दस्तावेजी साक्ष्य की उपधारणा के आधार पर आरोपों को विधि विरुद्ध तरीके से साबित मान लिया गया। न्यायालय में भी साक्ष्य के दौरान आरोपों के सम्बन्ध में कोई साक्ष्य पेश नहीं हुई। विपक्षी की ओर से जिन 2 गवाहान को साक्ष्य में प्रस्तुत किया गया, उसमें से एक गवाह जांचकर्ता है तथा दूसरा गवाह प्रबन्धन प्रतिनिधि था, उनकी साक्ष्य से भी आरोप साबित नहीं है, तथा उक्त आरोप के आधार पर प्रार्थी के विरुद्ध जो दण्ड पारित किया गया, वह पूर्णतः विधि विरुद्ध है, जिसे अपास्त किया जावे।

उपरोक्त तर्कों का खण्डन करते हुए विद्वान अधिवक्ता विपक्षी का तर्क है कि इस मामले में प्रार्थी के विरुद्ध आरोपों के सम्बन्ध में घरेलु जांच विधि सम्मत तरीके से की गई। प्रार्थी को सुनवाई का पूर्ण अवसर प्रदान किया गया। दस्तावेजी साक्ष्य से प्रार्थी के विरुद्ध लगाये गये आरोप पूर्णतः प्रमाणित हैं, इसके अलावा न्यायालय में आरोपों के सम्बन्ध में जो साक्ष्य आई हैं, उसमें भी प्रार्थी के विरुद्ध लगाये गये आरोप प्रमाणित हुए हैं, जिसके आधार पर प्रार्थी के विरुद्ध दण्डादेश पारित किया गया वह पूर्णतः विधि सम्मत है। अतः प्रार्थी का क्लेम खारिज किये जाने की प्रार्थना की।

दोनों पक्षों की ओर से लिये गये तर्कों के आधार पर इस प्रकरण में न्यायालय में सक्षम सरकार की ओर से प्राप्त रेफरेन्स जिसमें इस न्यायालय को यह अभिनिर्धारित करना है कि क्या प्रार्थी के विरुद्ध लगाये गये आरोप प्रमाणित हैं तथा उन आरोपों के आधार पर विपक्षी द्वारा प्रार्थी को पदावनत किये जाने का जो आदेश पारित किया गया वह विधि सम्मत है या नहीं?

इस प्रकरण में सक्षम सरकार की ओर से रेफरेन्स प्राप्त होने के पश्चात् प्रकरण में सुनवाई के दौरान दिनांक 05.09.2012 को इस न्यायालय द्वारा संबंधित रेफरेन्स में सेवामुक्ति से संबंधित विवाद न होने के कारण तथा यूनियन द्वारा मांग पत्र पर रेफरेन्स प्रेषित होने के फलस्वरूप दोनों पक्षों को साक्ष्य के पश्चात् प्रकरण में रेफरेन्स में निर्णय पारित किये जाने का आदेश प्रदान किया गया था तथा उक्त सम्बन्ध में दोनों पक्षों को साक्ष्य प्रस्तुत करने का आदेश पारित किया गया था।

प्रकरण के लम्बन के दौरान ही दिनांक 04.10.2019 को इस न्यायालय द्वारा रेफरेन्स में दिनांक 03.10.2007 का गलत अंकन होना पाया जाने तथा दोनों पक्षों द्वारा स्वीकृत तथ्यों के आधार पर स्टेटमेंट आफ क्लेम में दिनांक संशोधित किये जाने की अनुमति प्रदान कर दिनांक 03.10.2007 के स्थान पर दिनांक 10/11 अक्टूबर, 2007 किये जाने के आदेश प्रदान किये गये।

उपरोक्त न्याय निर्णयन के सम्बन्ध में प्रार्थी की ओर से जो साक्ष्य प्रस्तुत हुई हैं प्रार्थी A.W-1 रघुनाथसिंह व A.W-2 एस.एम. अय्यर ने प्रार्थी के प्रार्थना पत्र की पुष्टि करते हुए यह प्रकट किया है कि विपक्षी की ओर से प्रार्थी की वेतन

श्रृंखला को पदावन्त करने हेतु जो दण्ड पारित किया, उस हेतु जो जांच कार्यवाही विपक्षी की ओर से की गई, उसमें विपक्षी ने नैसर्गिक न्याय के सिद्धान्तों की पालना नहीं की, प्रार्थी को सुनवाई का अवसर नहीं दिया, प्रार्थी को बचाव में साक्ष्य प्रस्तुत करने हेतु अत्यन्त अल्प समय प्रदान किया, जबकि विपक्षी को 7 माह का समय प्रदान किया गया था। जांच में विपक्षी की ओर से प्रस्तुत गवाह की मौखिक साक्ष्य से कोई भी आरोप प्रमाणित नहीं हुआ है तथा जांच के दौरान किसी भी दस्तावेज को प्रदर्शित नहीं कराया गया। दस्तावेजों को साक्ष्य में टेण्डर किये बगैर ही मात्र उपधारणा के आधार पर आरोप प्रमाणित मानते हुए प्रार्थी को दण्डित किया गया। प्रार्थी की ओर से विपक्षी कम्पनी के स्थायी आदेशों के विरुद्ध कोई कार्य नहीं किया गया। सहकारी समिति के गठन की जानकारी विपक्षी को थी, उन्होंने जानकारी के पश्चात् भी प्रार्थी को समिति में भाग लेने से नहीं रोका। इस प्रकार विपक्षी की मौन स्वीकृति समिति में प्रार्थी के बने रहने बाबत थी, उक्त समिति के द्वारा कोई लाभ अर्जित किया गया हो—विपक्षी की ओर से प्रस्तुत साक्ष्य से यह तथ्य भी साबित नहीं है। झूठी शिकायत के आधार पर प्रार्थी के विरुद्ध कार्यवाही की गई। जिसे अपास्त किये जाने की प्रार्थना की गई तथा दस्तावेजी साक्ष्य के रूप में प्रदर्श-1 लगायत प्रदर्श-28 को प्रदर्शित कराया गया।

इसके विपरीत विपक्षी की ओर से प्रस्तुत N.A.W-2 चेनालिट बालन राजन ने भी अपनी साक्ष्य में प्रार्थी के विरुद्ध विधि अनुसार घरेलु जांच किया जाना तथा समस्त आरोप प्रमाणित पाये जाने पर जांच रिपोर्ट जनरल मैनेजर को सुपुर्द किया जाना अपनी साक्ष्य में बताया है। दस्तावेजी साक्ष्य के रूप में विपक्षी की ओर से ExM-1 लगायत ExM-12 को प्रदर्शित कराया गया।

दोनों पक्षों की ओर से प्रस्तुत साक्ष्य के पश्चात् इस मामले में जो तथ्य सामने आये हैं, उसमें विपक्षी की ओर से प्रार्थी को दिनांक 22.04.06 को प्रदर्श-3 आरोप पत्र प्रदान किया गया, जिसमें प्रार्थी के विरुद्ध यह आरोप था कि उसने विपक्षी कम्पनी के स्थायी आदेश की धारा 20 का उल्लंघन कर स्थायी आदेश संख्या 21 के अन्तर्गत अनुच्छेद 21 (a) (ii) (viii) (xii) (xxii) (xxiv) एवं (xxxii) के तहत गम्भीर दुराचरण की परिभाषा में आता है और इस बाबत आरोप पत्र प्रदान किया गया।

इस सम्बन्ध में प्रार्थी की ओर से प्रदर्श-4 अपना जवाब प्रस्तुत किया। तत्पश्चात् इस मामले में प्रार्थी के विरुद्ध लगे आरोप के सम्बन्ध में जांच कार्यवाही प्रारम्भ की गई तथा बाद जांच प्रदर्श-5 जांच रिपोर्ट जांच अधिकारी द्वारा दिनांक 23.09.2007 को तैयार की गई, जिसमें प्रार्थी के विरुद्ध जांच में लगाये गये आरोप को प्रमाणित माने गये और उस संदर्भ में प्रार्थी को सुनवाई का अवसर भी विपक्षी द्वारा दिया गया और जांच में दोषी पाया जाने पर आदेश दिनांक 10/11 अक्टूबर, 2007 को दण्डादेश पारित कर उसे पदावन्त के दण्ड से दण्डित किया गया।

इस मामले में विपक्षी की ओर से घरेलु जांच ExM-12 प्रस्तुत हुई है, जिसके सम्बन्ध में प्रार्थी की ओर से प्रथम आक्षेप यह प्रकट किया गया कि घरेलु जांच में उसे सुनवाई का पर्याप्त अवसर नहीं मिला तथा नैसर्गिक न्याय के सिद्धान्तों की अवहेलना होना बताया गया। इस बाबत प्रार्थी की ओर से यह भी प्रकट किया गया कि घरेलु जांच में विपक्षी को 7 माह का अवसर दिया गया, जबकि प्रार्थी को अत्यधिक अल्प अवधि साक्ष्य हेतु प्रदान की गई।

इस सम्बन्ध में जो साक्ष्य प्रस्तुत हुई है उसमें A.W-1 रघुनाथसिंह ने न्यायालय में दी गई अपनी साक्ष्य में जिरह में यह स्वीकार किया है कि यह सही है कि घरेलु जांच में उसे साक्ष्य पेश करने के लिये दो अवसर प्रदान किये थे, जिसमें उसने अपनी साक्ष्य पेश कर दी थी। अतः प्रार्थी की साक्ष्य से यह पूर्णतः साबित होता है कि उसकी ओर से घरेलु जांच में बचाव में अपनी समस्त साक्ष्य प्रस्तुत कर दी थी। प्रार्थी की ओर से कोई साक्ष्य प्रस्तुत करने से उसे वंचित किया गया हो, यह तथ्य प्रार्थी की ओर से प्रकट नहीं किया गया है। अतः इस मामले में साक्ष्य से यह पूर्णतः साबित होता है कि घरेलु जांच में प्रार्थी को सुनवाई का पर्याप्त अवसर प्रदान किया गया था।

प्रार्थी के विरुद्ध घरेलु जांच में उसके विरुद्ध जो आरोप प्रदर्श-3 के तहत लगाये गये थे जो आरोप निम्न प्रकार से हैं —

- (1) 21(a) (ii) —  
संस्थान के व्यवसाय एवं सम्पत्ति की चोरी या धोखाधड़ी या उसके सम्बन्ध में कोई बेईमानी करना।
- (2) 21 (a) (viii) —  
कम्पनी के बिना पूर्व स्वीकृति के संस्थान की परिसीमाओं में कोई व्यापार अथवा व्यवसाय करना, जिसमें कामगारों को दी हुई वेतन पर्चियां को इकट्ठा करना अथवा टिकिटों को बेचना अथवा उनके लिये प्रचार करना, किसी वस्तु के कूपन अथवा दूसरे टोकन बेचना अथवा खरीदने एवं बेचने हेतु प्रचार करना।
- (3) 21 (a) (xii) —  
संस्थान की सम्पत्ति को जान बुझ कर क्षतिग्रस्त करना अथवा क्षतिग्रस्त करने का प्रयत्न करना अथवा संस्थान की अन्य सम्पत्ति अथवा संस्थान के ग्राहकों की सम्पत्ति को क्षतिग्रस्त करना अथवा क्षतिग्रस्त करने का प्रयास करना।
- (4) 21 (a) (xxii) —  
कोई ऐसा कार्य करना जो कि कम्पनी के हितों के विपरीत हो अथवा घोर लापरवाही, जिसके कारण कम्पनी को गम्भीर क्षति पहुंचे अथवा पहुंचने की संभावना हो।
- (5) 21 (a) (xxiv) —  
भारतीय खदान अधिनियम अथवा अन्य किसी अधिनियम अथवा अन्य नियमों अथवा उनके अन्तर्गत बने हुए उप-नियमों अथवा इन स्थायी आदेशों का जान बुझ कर उल्लंघन करना।



उक्त आरोपों के सम्बन्ध में घरेलु जांच में जो गवाह प्रस्तुत हुए हैं उसमें किसी भी गवाह ने अपनी मौखिक साक्ष्य में उन आरोपों की पुष्टि नहीं की है, इस सम्बन्ध में घरेलु जांच प्रदर्श-12 के दौरान जांच अधिकारी ने दस्तावेजों को जिनके आधार पर अपनी जांच में निष्कर्ष निकाला है, किसी भी दस्तावेज को साक्ष्य में टेण्डर नहीं किया, न ही प्रदर्शित कराया गया। किसी भी गवाह ने मौखिक साक्ष्य में उन दस्तावेजों को प्रदर्शित नहीं किया और न ही टेण्डर किया। इसके अलावा न्यायालय में साक्ष्य के दौरान विपक्षी की ओर से अपनी घरेलु जांच में ऐसे किसी भी गवाह को प्रस्तुत नहीं किया जो आरोपित आरोप के सम्बन्ध में दस्तावेजों को न्यायालय में प्रदर्शित करे, इस सम्बन्ध में विपक्षी की ओर से जो मौखिक साक्ष्य प्रस्तुत हुई, उसमें विपक्षी की ओर से N.A.W-2 चेनालिट बालन राजन ने न्यायालय में दी गई अपनी साक्ष्य में जिरह में यह स्वीकार किया है कि मैनेजमेन्ट की ओर से जांच में दस्तावेजों को प्रदर्शित नहीं कराया। आगे अपनी जिरह में यह भी स्वीकार किया कि प्रार्थी के विरुद्ध किसी भी गवाह ने मौखिक साक्ष्य में भ्रष्टाचार बाबत नहीं बताया। दस्तावेजों से प्रार्थी के विरुद्ध जांच में भ्रष्टाचार साबित हुआ था।

जबकि इसके विपरीत विपक्षी की ओर से N.A.W1 डॉ. सुनिल सिंह दहिया पेश हुए हैं जो घरेलु जांच में प्रार्थी के विरुद्ध मैनेजमेन्ट प्रतिनिधि था, उसने अपनी जिरह में यह स्वीकार किया है कि जांच पश्चात् हमने प्रार्थी के विरुद्ध भ्रष्टाचार का आरोप साबित नहीं पाया। आरोप पत्र प्रदर्श-3 में प्रार्थी के विरुद्ध लगाये गये आरोप जांच कार्यवाही में प्रार्थी के विरुद्ध वाणिज्यिक गतिविधियों में सम्मिलित रहने बाबत कोई मौखिक साक्ष्य पेश नहीं हुई है। दस्तावेजी साक्ष्य में जो दस्तावेज पेश हुए हैं, उनको साबित करने के लिये कोई गवाह जांच में पेश नहीं हुआ। इस गवाह ने अपनी जिरह में यह भी प्रकट किया कि यह सही है कि करणीलाल शर्मा जिसने शिकायत की थी, उसे जांच में साक्ष्य हेतु बुलाया गया था, लेकिन वह उपस्थित नहीं हुआ। इस प्रकार जांच कार्यवाही में दस्तावेजों की उपधारणा के आधार पर प्रार्थी पर लगे उक्त आरोप के सम्बन्ध में उसे दोषी घोषित किया गया था, यह तथ्य विपक्षी की साक्ष्य से प्रकट होता है।

प्रार्थी के विरुद्ध उक्त आरोपों के सम्बन्ध में न्यायालय में जो साक्ष्य प्रस्तुत हुई हैं उसमें प्रार्थी व विपक्षी की ओर से मौखिक एवं दस्तावेजी साक्ष्य प्रस्तुत हुई, जिसमें प्रार्थी के विरुद्ध मुख्य रूप से यह आरोप है कि प्रार्थी ने विपक्षी संस्थान में नियमित कर्मचारी के रूप में नियुक्ति के दौरान विपक्षी संस्थान की अनुमति के बिना स्थायी आदेश के विपरीत सहकारी समिति का लाभ प्राप्त करने के उद्देश्य से गठन किया तथा लाभ प्राप्त किया, उसका पंजीयन कराया तथा पंजीयन कराते समय पंजीयक को बेईमानी पूर्वक गलत सूचना दी तथा स्वयं को विपक्षी संस्थान में नौकरी करने के तथ्य को छुपाया तथा साथ ही विपक्षी संस्थान के परिसर का विपक्षी की अनुमति के परिसर का उपयोग कर विपक्षी के व्यवसाय व ख्याति को क्षति पहुंचाई।

उपरोक्त आरोप पत्र में पृथक-पृथक आरोप से जांच कार्यवाही में आरोपित कर जांच अधिकारी ने सभी आरोपों को साबित माना था, जो उपरोक्त विश्लेषण से यह प्रकट होता है कि उक्त आरोपों के सम्बन्ध में न तो किसी भी गवाह ने मौखिक साक्ष्य में बताया तथा जो दस्तावेजी साक्ष्य प्रस्तुत हुई हैं, वह विधि अनुसार साबित नहीं हुए, उक्त आरोपों के सम्बन्ध में न्यायालय में जो दोनों पक्षों की ओर से साक्ष्य प्रस्तुत हुई, उसमें प्रार्थी द्वारा सहकारी समिति के गठन के लिये समिति के पंजीयन हेतु प्रस्तुत आवेदन पत्र प्रदर्श-11 है, जिसके साथ सहकारी समिति के सदस्यों की सूची है, जो प्रदर्श-12 है, उसमें क्रम संख्या 3 पर प्रार्थी के नाम का उल्लेख है, इसमें इस तथ्य का वर्णन भी है कि प्रार्थी नौकरी करता है। समिति के गठन का उद्देश्य व उसके संविधान के बाबत नियम प्रदर्श-13 है, जिसमें समिति के कार्य क्षेत्र का वर्णन है और इस तथ्य का उल्लेख है कि सहकारी समिति का उद्देश्य सदस्यों के लिये ठेका लेकर लाभ दायक उद्यम प्राप्त करना है। इस उद्देश्य से सहकारी समिति के सदस्यों के लाभ के उद्देश्य से गठन किया जाना प्रकट होता है।

प्रदर्श-11, 12 व 13 के अवलोकन से यह प्रकट होता है कि समिति के पंजीयन हेतु जो आवेदन पत्र पंजीयक के यहां प्रस्तुत किया गया था, उसमें सदस्यों के नाम, पता व व्यवसाय आदि का वर्णन है, किसी तथ्य को छुपाया नहीं गया है, इसके आधार पर पंजीयक की ओर से पंजीयन प्रमाण पत्र ExM-11 जारी किया गया, जिससे दिनांक 24.03.2004 को समिति का पंजीयन किया जाना प्रकट होता है। इस सम्बन्ध में प्रार्थी के विरुद्ध स्थायी आदेश 21 (a) (xxiv) के सम्बन्ध में जो आरोप लगाये गये, जिन्हें साबित होना विपक्षी ने माना है, इस बाबत यह उल्लेख है कि प्रार्थी ने समिति के गठन के समय उप रजिस्ट्रार सहकारी समितियां उदयपुर को अंधेरे में रख कर यह जानकारी उपलब्ध नहीं कराई कि प्रस्तावित समिति के सदस्य एवं पदाधिकारी विपक्षी कम्पनी के कर्मचारी हैं या नहीं? जबकि इस सम्बन्ध में प्रार्थी की ओर से प्रस्तुत प्रदर्श-11, 12 व प्रदर्श-13 से यह पूर्णतः साबित होता है कि प्रार्थी की ओर से सहकारी समिति के गठन के सम्बन्ध में उप रजिस्ट्रार को जो आवेदन पत्र प्रस्तुत किया था, उसमें विधि अनुसार सदस्यों के नाम, पत्ते, व्यवसाय आदि की जानकारी दी थी। इस बाबत रजिस्ट्रार को कोई स्पष्टीकरण चाहिये था तो वह सदस्यों से प्राप्त कर सकता था। उपरोक्त दस्तावेजों से यह तथ्य भी साबित होता है कि विपक्षी संस्थान में कार्यरत व्यक्ति ही उक्त समिति के सदस्य हो सकते थे तथा साक्ष्य से यह साबित नहीं हुआ है कि समिति के पंजीयन के समय उप रजिस्ट्रार को प्रार्थी द्वारा अंधेरे में रख कर पंजीयन कराया गया।

इस प्रकरण में प्रस्तुत साक्ष्य से यह स्वीकृत तथ्य सामने आया है कि प्रार्थी ने विपक्षी संस्थान में ठेका मजदूरों के साथ मिलकर सहकारी समिति का गठन किया था और उसका पंजीयन दिनांक 24.03.2004 को कराया। पंजीयन कराने से पूर्व जो पंजीयन कराने की प्रक्रिया हुई तथा जो आवेदन पत्र प्रस्तुत किया गया था, के सम्बन्ध में कोई भी पूर्व अनुमति सहकारी समिति के गठन के लिये प्रार्थी की ओर से विपक्षी से नहीं ली गई थी। इस सम्बन्ध में प्रार्थी की ओर से यह प्रकट किया गया है कि दिनांक 24.03.2004 को विपक्षी कम्पनी के पदाधिकारी के समक्ष प्रार्थी की ओर से प्रदर्श-14 आवेदन पत्र प्रस्तुत किया था, जिससे विपक्षी कम्पनी की जानकारी में यह तथ्य आ गया था कि प्रार्थी जो “श्री ज्ञानेश्वर श्रमिक ठेका सहकारी समिति” का सचिव है। उक्त समिति के गठन हेतु पंजीकरण की कार्यवाही लम्बित है, उक्त पत्र दिनांक 24.03.2004 में विपक्षी की जानकारी में आना प्रदर्श-14 से साबित है तथा ExM-11 पंजीयन प्रमाण पत्र से यह साबित होता है कि दिनांक 24.03.2004 को सहकारी समिति का गठन हुआ, इस प्रकार उक्त समिति के गठन से पूर्व कोई अनुमति प्रार्थी द्वारा विपक्षी से लिया जाना साबित नहीं होता है, लेकिन गठन के दिन, उक्त समिति के गठन होने की जानकारी विपक्षी को होना प्रदर्श-14 से साबित है। विपक्षी की ओर से प्रदर्श-15 पत्र प्रार्थी को सहकारी समिति के गठन बाबत जारी कर स्पष्टीकरण चाहे गये, जिस सम्बन्ध में प्रार्थी की ओर से जबाब प्रदर्श-16 प्रस्तुत किया गया है। इन समस्त पत्रों के अवलोकन से यह पूर्ण रूपेण साबित होता है कि विपक्षी को सहकारी समिति के गठन तथा



प्रार्थी के सचिव होने की पूर्ण जानकारी थी, इसके पश्चात् भी विपक्षी की ओर से प्रार्थी को उक्त कृत्य से नहीं रोका गया, जिससे प्रार्थी की ओर से समिति में बने रहने के सम्बन्ध में विपक्षी की मौन स्वीकृति होना साक्ष्य से साबित है।

विपक्षी कम्पनी के स्थायी आदेश के विपरीत प्रार्थी ने समिति के माध्यम से व्यवसाय कर लाभ अर्जित किया, इस सम्बन्ध में न तो जांच कार्यवाही के समय और न ही न्यायालय में हुई कार्यवाही के दौरान कोई साक्ष्य विपक्षी की ओर से प्रस्तुत हुई। अतः साक्ष्य के अभाव में उक्त आरोप के सम्बन्ध में यह तथ्य साबित नहीं होता है कि प्रार्थी ने सहकारी समिति के माध्यम से व्यवसाय कर लाभ अर्जित किया हो।

इसके अलावा प्रार्थी के विरुद्ध यह भी आरोप है कि उक्त सहकारी समिति का कार्यालय कम्पनी के परिसर में यूनियन को प्रदान किये गये परिसर को बता कर बगैर विपक्षी की अनुमति के विपक्षी के यूनियन के ऑफिस के रूप में उपयोग कर स्थायी आदेश का उल्लंघन किया गया। इस सम्बन्ध में प्रार्थी की ओर से प्रदर्श-11 सहकारी समिति के पंजीयन के लिये प्रेषित आवेदन पत्र में सहकारी समिति का जो पता वर्णित किया है, वह विपक्षी कम्पनी का परिसर होना साबित है, यह तथ्य इस प्रकरण में प्रकट होता है कि उक्त सहकारी समिति का जो पता पंजीयन के समय प्रस्तुत किया था, उसमें विपक्षी की अनुमति के बगैर विपक्षी संस्थान के परिसर में स्थित यूनियन के ऑफिस को दर्शाया गया है, लेकिन इस आरोप के सम्बन्ध में घरेलु जांच में व न्यायालय में ऐसी कोई साक्ष्य विपक्षी की ओर से प्रस्तुत नहीं हुई, जिससे यह साबित हो कि उक्त परिसर का उपयोग समिति के संचालन हेतु प्रार्थी ने किया हो, किसी भी गवाह ने अपनी मौखिक साक्ष्य में उक्त समिति का विपक्षी कम्पनी के परिसर में व्यवसाय हेतु संचालन किये जाने बाबत नहीं बताया है, न ही न्यायालय में साक्ष्य के दौरान विपक्षी की ओर से ऐसी कोई साक्ष्य प्रस्तुत की गई।

अतः दोनों पक्षों की ओर से प्रस्तुत साक्ष्य से इस मामले में प्रार्थी के विरुद्ध लगाये गये आरोप के सम्बन्ध में मात्र प्रार्थी ने विपक्षी संस्थान की पूर्व अनुमति लिये बगैर उक्त समिति का गठन किया, लेकिन गठन के दिन ही विपक्षी की जानकारी में प्रार्थी की ओर से समिति के गठन के सम्बन्ध में सूचना दे दी थी, उसके पश्चात् भी विपक्षी की ओर से समिति के गठन के बाबत कोई ऐतराज नहीं किया गया, जिससे विपक्षी कम्पनी की समिति के गठन बाबत मौन स्वीकृति होना साबित है तथा उसके 2 वर्ष पश्चात् इन आरोप के बाबत प्रार्थी के विरुद्ध स्थायी आदेशों के उल्लंघन बाबत आरोप पत्र दिया गया है। सहकारी समिति के गठन कर प्रार्थी ने व्यवसाय कर कोई लाभ अर्जित किया हो, इस बाबत न तो जांच के दौरान, न ही न्यायालय में साक्ष्य के दौरान ऐसी कोई साक्ष्य प्रस्तुत हुई, जिससे यह साबित होता कि प्रार्थी ने सहकारी समिति के माध्यम से व्यवसाय कर लाभ अर्जित किया हो। इसके अलावा विपक्षी के परिसर में सहकारी समिति के द्वारा व्यवसाय का संचालन किया हो, यह तथ्य भी साक्ष्य के अभाव में साबित नहीं होता है।

इसके अलावा इस प्रकरण में प्रार्थी की ओर से कम्पनी की ख्याति में क्षति पहुंचाने बाबत आरोप भी साबित माना गया है, लेकिन इस आरोप के सम्बन्ध में न तो जांच के समय और न ही न्यायालय में साक्ष्य के दौरान कोई साक्ष्य प्रस्तुत हुई, जिससे यह साबित होता हो कि कम्पनी की ख्याति को उक्त समिति का गठन कर प्रार्थी ने क्षति पहुंचाई।

फलस्वरूप उपरोक्त विश्लेषण से विपक्षी कम्पनी द्वारा प्रार्थी के विरुद्ध जारी आरोप पत्र प्रदर्श-3 में लगाये गये आरोप साबित नहीं होते हैं, तथा उक्त आरोपों के आधार पर विपक्षी द्वारा जारी दण्डादेश दिनांक 10/11 अक्टूबर, 2007 प्रदर्श-8 पारित किया गया वह उचित एवं वैध नहीं है।

विपक्षी द्वारा जारी आदेश प्रदर्श-8 अवैध है, इसलिये प्रार्थी उक्त तिथि से उसको मिलने वाले सभी लाभ प्राप्त करने का अधिकारी होगा।

अतः भारत सरकार द्वारा प्रेषित प्रसंग दिनांक 28/05/2009 को उत्तरित करते हुये पंचाट इस प्रकार पारित किया जाता है कि—

“विपक्षी जनरल मैनेजर, राजस्थान स्टेट माईन्स एण्ड मिनरल्स लि0 झामरकोटडा द्वारा प्रार्थी रघुनाथसिंह पिता गोवर्धनसिंह साखला सिनीयर असिस्टेंट ग्रेड-1 वर्कमेन नम्बर 16266 को 7400-11600 से 6700-10660 में पदावनत (Demote) करने का जो आदेश प्रदर्श-8 दिनांक 10/11 अक्टूबर, 2007 किया गया वह अनुचित एवं अवैध है।

इसलिये उक्त पदावनति आदेश जारी होने से पूर्व प्रार्थी जिस वेतन श्रृंखला में वेतन प्राप्त कर रहा था, उसी वेतन श्रृंखला में वेतन प्राप्त करने का अधिकारी है तथा उस अनुरूप जो भी परिलाभ होते हैं, वे सभी परिलाभ प्राप्त करने का अधिकारी है, उन सभी की गणना करके अन्तर राशि का विपक्षी पंचाट प्रकाशन से 90 दिन की अवधि में प्रार्थी को भुगतान करे, अन्यथा उक्त अवधि के पश्चात् उक्त बकाया राशि पर 7 प्रतिशत वार्षिक दर से ब्याज देय होगा।

पंचाट प्रकाशनार्थ भारत सरकार को भेजा जावे।

अरुण कुमार दूबे, पीठासीन अधिकारी

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 692.**—औद्योगिक विवाद अधिनियम 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स पीयूष इंजीनियरिंग एवं अन्य के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, भुवनेश्वर के पंचाट (संदर्भ संख्या 76/2016) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. जेड-16025/4/2020-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 692.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 76/2016) of the Central Government Industrial Tribunal/Labour Court, Bhubaneswar now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Piyush Engineering and other, and their workman, which was received by the Central Government on 05.08.2020.

[No. Z-16025/4/2020-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE**

**IN THE COURT OF THE PRESIDING OFFICER, C.G.I.T-CUM-LABOUR COURT,  
BHUBANESWAR**

**INDUSTRIAL DISPUTE CASE NO. 76 OF 2016**Dated Bhubaneswar, the 28<sup>th</sup> August, 2019**Present:**

Shri B.C. Rath  
Presiding Officer,  
C.G.I.T.-cum-Labour Court,  
Bhubaneswar.

**Between:**

1. M/s. Piyush Engineering (Contrator),  
C/oM/s. Runguta Mines Limited,  
Jajang Iron & Mn. Mines, At/P.O. Jajang,  
Via – Joda, P.S. Bamebari,  
Dist. Keonjhar, Odisha.

2. M/s. Runguta Mines Limited,  
Jajang Iron & Mn. Mines, At/P.O. Jajang,  
Via: Joda, P.s: Bamebari,  
District - Keonjhar, Odisha.

...First Party managements

**AND**

Sri Fakir Mohan Majhi,  
Jagannathpur, P.O: Belda, Via: Joda,  
P.S: Bamebari, Dist: Keonjhar, Odisha

...Second Party workman

**Appearances:**

Shri J.P. Chourasia : For first party management No. 1  
Shri B.R. Das : For first party management No. 2  
NONE : For second party workman

**ORDER**

Authorised representatives of the managements are present. None appears on behalf of the second party workman on repeated calls. It is submitted by the learned counsel for the management that the applicant workman is not taking any step since long and as such, the case shall be dismissed for default of the applicant workman. Perused the case record. It is found that the applicant workman is not taking steps for last eight adjournments inspite of specific direction for his personal attendance. After filing of statement of claim, he seems to be absent in all dates of adjournments. No award can be passed without evidence of the applicant workman and as such, I am constrained to dismiss the case instituted directly resorting to the provisions of Section 2-A (2) of the Industrial Disputes Act.

Dictated &amp; corrected by me.

B. C. RATH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ.693.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स इंद्राणी पटनायक आयरन एंड मैंगनीज माइंस एवं अन्य के प्रबंधन के संबद्ध नियोजकों और उनके कर्मकारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, भुवनेश्वर के पंचाट (संदर्भ संख्या 33/2017) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. जेड-16025/4/2020-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 693.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 33/2017) of the Central Government Industrial Tribunal/Labour Court, Bhubaneswar now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Indrani Pattanaik Iron & Manganese Mines and other, and their workman, which was received by the Central Government on 05.08.2020.

[No. Z-16025/4/2020-IR(M)]

A. K. SINGH, Under Secy.

#### ANNEXURE

#### IN THE COURT OF THE PRESIDING OFFICER CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT, BHUBANESWAR

#### I.D. Case No.33 of 2017

- |                 |   |                                     |
|-----------------|---|-------------------------------------|
| 1.              | The Managing Director,<br>M/s. Indrani Pattanaik Iron & Manganese Mines,<br>At- Unchabali, PO – Bamebari,<br>Dist: Keonjhar, Odisha, Pin – 758086 | ...1 <sup>st</sup> Party Management |
| 2.              | The Manager,<br>M/s. Triveni Earthmovers Pvt. Ltd.<br>At- Unchabali, PO – Bamebari,<br>Dist: Keonjhar, Odisha, Pin – 758086                       | ...Contractor                       |
| <b>-Versus-</b> |   |                                     |
|                 | Sri Batua Munda<br>At – Tadapani (B Plot), P.S. – Bamebari,<br>Via- Balada, Dist: Keonjhar, Odisha.   | ...2 <sup>nd</sup> Party Workman    |

#### I.D. Case No.33 of 2017

- 16) 24-06-2019      The applicant workman Batua Munda is present so also the authorized representative of the 1<sup>st</sup> Party Management. A petition for with drawal of the case along with a memorandum of settlement signed by the applicant and the 1<sup>st</sup> Party Management is filed wherein and whereby it has been mentioned that the parties have arrived at a settlement by which the 2<sup>nd</sup> Party workman has received a demand draft of Rs. 1,50,000/- on 21-06-2019 for a settlement with the Management that he would not prosecute the proceeding and with draw the dispute in the event of the settlement. He will not claim any back wages, compensation terminal benefits, service benefits in any nature and he would file application for with drawal of the case. On being asked the applicant volunteered that the petition for with drawal of the case along with the settlement is filed on his own volition. He was aware of the contents of the petition and settlement since it was read over the explained to him. He was signed the petition and the settlement understanding the contents and knowing the consequence of the case. Be that as it may, the claim statement filed in shape of an application under sub section 2 and 3 of Section -2(A) of the I.D. Act stand withdrawn with an award as per term and condition of the settlement filed by the parties. The settlement becomes a part of the award.

The award be notified as per the provisions of law.

Dictated & corrected by me.

B. C. RATH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 694.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स एस.डी. शर्मा नौगांव आयरन माइंस के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, भुवनेश्वर के पंचाट (संदर्भ संख्या 32/2004) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-26011/3/2004-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 694.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 32/2004) of the Central Government Industrial Tribunal/Labour Court, Bhubaneswar now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. S.D. Sharma Naogaon Iron Mines, and their workman, which was received by the Central Government on 05.08.2020.

[No. L-26011/3/2004-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE****I.D Case No. 32 of 2004**

Shri S.D. Sharma,  
Proprietor M/s. S.D.Sharma Naogaon Iron Mines,  
At/P.O. Barbil, Dist-Keonjhar(Orissa)

...1<sup>st</sup> Party Management**-Versus-**

The General Secretary, North Orissa Workers Union,  
At/P.O.Barbil, Dist. Keonjhar (Orissa).

...2<sup>nd</sup> Party Union

67) 13.08.2019

Authorised Representatives of the parties are present. Authorised Representative of the 2<sup>nd</sup> Party Union submits that the disputant workmen are unable to attend the Tribunal at Bhubaneswar due to their financial hardship. Unless the case is heard either in Camp Court at Keonjhar or at Rourkela they are not in a position to attend and adduce their evidence. On perusal of the order sheets it is found that on the submission of the 2<sup>nd</sup> Party the case was posted earlier at Rourkela camp on different occasions. But, the 2<sup>nd</sup> Party took adjournments on those occasions. The record further reveals that this is a reference case of the year 2004 and after filing of statements by the parties and settlement of issues the case is protracting for last 10 years to take evidence of the disputant workmen. The parties to the case are found to have been playing hide and seek on the day of hearing either by remaining absent or taking adjournments for some plea. The case has already suffered more than 70 adjournments after its institution and the 2<sup>nd</sup> Party is yet to adduce evidence despite the case was fixed for hearing in camp court at Keonjhar as well as at Rourkela. In the above back drops it cannot be ruled out that the 2<sup>nd</sup> Party Workmen might have lost their interest to prosecute their dispute.

2. The Workmen seems to have challenged their dismissal on a contention that the same was illegal due to non-compliance of the requirement of Sec.25-f of the I.D. Act.

Such a dispute cannot be adjudicated and award cannot be passed as defined U/s.2-(b) of the Act in absence of any evidence from the side of the workmen.

3. It is pertinent to mention here that until adjudication of the dispute referred to by the authority concerned, an award cannot be made within the meaning of the award as defined under section 2(b) of the Act. There is also no provision in the Act to pass a no-dispute award or a nil award in case the disputant fails to make appearance and prosecute its claim. In that view of the matter passing of a no-dispute award or nil award for absence of the disputant/parties would be a

misconception and the above position has been settled by the Hon'ble High Court of Orissa in the case between M/s.IDL Chemicals Limited –Versus- P.O, Labour Court, Sambalpur reported in 72(1991)CLT 73 and in the decision of the Calcutta High Court in the case of B.R.Bermen and Mohatta (India)Pvt. Ltd., -Versus- Seventh Industrial Tribunal, West Bengal and others (short noted in 1977 Lab. I.C (NOC)13 (CAL). It has been also held by the Hon'ble Courts that so long as the dispute remains unsettled and the proceeding came to an end without adjudication of the dispute between the parties, there is no bar under the Act whereby the Government is precluded from referring the dispute over again so that there may be an industrial adjudication as contemplated by the Act.

4. Having regard to the above facts and circumstances as well as settled principles I am constrained to dismiss the case registered on the reference of the dispute without any award and accordingly the reference is disposed of. A copy of this order be sent to the Government of India, Ministry of Labour for necessary action at their end.

Dictated and corrected by me.

B. C. RATH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 695.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स अग्रवाल ब्रदर्स के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, भुवनेश्वर के पंचाट (संदर्भ संख्या 15/2001) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-29011/35/1995-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 695.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 15/2001) of the Central Government Industrial Tribunal/Labour Court, Bhubaneswar now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Agarwal Brothers, and their workman, which was received by the Central Government on 05.08.2020.

[No. L-29011/35/1995-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE**

**CENTRAL GOVT. INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT, BHUBANESWAR**

**Industrial Dispute Case No. 15 of 2001**

**Beteen:**

M/s. Agarwal Brothers,  
At- Dhanigadia,  
P.O. & District-Bhadrak-756100

...1<sup>st</sup> Party- Management

**-Versus-**

The General Secretary,  
Chrome Zone Employees Union,  
At/P.O. Saso, District-Keonjhar-756115

...2<sup>nd</sup> Party Workman/Union

141) 19.8.2019 None appears on repeated calls from either sides i.e for the 2<sup>nd</sup> Party Union as well as for the 1<sup>st</sup> Party Management. Perusal of the record reveals that neither the 2<sup>nd</sup> Party Union nor the Management are taking any steps though the Reference No. L-29011/35/95-IR(Misc.) relates to the year 1996. Initially the reference case was registered in the State Industrial Tribunal, Bhubaneswar and in the event of functioning of this Tribunal i.e



CGIT, Bhubaneswar the case was received on transferred in this Tribunal. Further hearing/proceeding of the Tribunal is stayed by the Hon'ble High Court in OJC. No.10229/2000. In the mean while the said O.J.C is disposed of by the Hon'ble High Court and the Tribunal is directed to dispose of the reference case as expeditiously as possible. Thereafter, the 2<sup>nd</sup> Party Union appeared before this Tribunal. But the Management fails to appear inspite of service of notice through ALC, Bhubaneswar. In the mean while the 2<sup>nd</sup> Party Union also failed to take steps in the matter. The case cannot be allowed to linger for an indefinite period, keeping in view the direction of the Hon'ble High Court passed in the O.J.C. and the fact that the reference relates to the year 1996. The record further reveals that no evidence was adduced before issue of stay of the Hon'ble High Court. Non-appearance of the 2<sup>nd</sup> Party Union leads to an inference that it might have lost its interest to prosecute the dispute arose in the year 1996. The dispute relates to alleged illegal termination of services of 18 workmen. Such dispute cannot be adjudicated without evidence from the side of the 2<sup>nd</sup> Party Union. As such no award in term as defined U/s.2-(b) of the Act can be passed.

It is pertinent to mention here that until adjudication of the dispute referred to by the authority concerned, an award cannot be made within the meaning of the award as defined under section 2(b) of the Act. There is also no provision in the Act to pass a no-dispute award or a nil award in case the disputant fails to make appearance and prosecute its claim. In that view of the matter passing of a no-dispute award or nil award for absence of the disputant/parties would be a misconception and the above position has been settled by the Hon'ble High Court of Orissa in the case between M/s.IDL Chemicals Limited -Versus- P.O, Labour Court, Sambalpur reported in 72(1991)CLT 73 and in the decision of the Calcutta High Court in the case of B.R.Bermen and Mohatta (India)Pvt. Ltd., -Versus- Seventh Industrial Tribunal, West Bengal and others (short noted in 1977 Lab. I.C (NOC)13 (CAL). It has been also held by the Hon'ble Courts that so long as the dispute remains unsettled and the proceeding came to an end without adjudication of the dispute between the parties, there is no bar under the Act whereby the Government is precluded from referring the dispute over again so that there may be an industrial adjudication as contemplated by the Act.

Having regard to the above facts and circumstances as well as settled principles I am constrained to dismiss the case registered on the reference of the dispute without any award and accordingly the reference is disposed of. A copy of this order be sent to the Government of India, Ministry of Labour for necessary action at their end.

Dictated and corrected by me.

B. C. RATH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 696.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स आन्ध्र सीमेंट्स लिमिटेड एवं अन्य के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 8/2017) को प्रकाशित करती है जो केन्द्रीय सरकार को 06.08.2020 को प्राप्त हुआ था।

[सं. एल-29012/32/2016-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 696.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 8/2017) of the Central Government Industrial Tribunal/Labour Court, Hyderabad now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Andhra Cements Limited and other, and their workman, which was received by the Central Government on 06.08.2020.

[No. L-29012/32/2016-IR(M)]

A. K. SINGH, Under Secy.



**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 12<sup>th</sup> day of March, 2020**INDUSTRIAL DISPUTE No. 8/2017****Between:**

Sri Palla Demudu Babu,  
S/o Yerrinaidu,  
Gullepalli (V),  
Sabbavaram (M),  
Distt. Visakhapatnam (A.P.)-531035

...Petitioner

**AND**

1. The Senior Vice President & Plant Head,  
Andhra Cements Limited, Jaypee Group,  
Visakha Cement Works, Porlupalem (Village),  
Post – Durganagar, Visakhapatnam (A.P.) – 530 029.

2. M/s. Aztech Services,  
Manpower Contractors,  
F-3, Sair Krishna Towers, Road No. 3,  
Jagannadha Raju Nagar, Venkojipalem,  
Visakhapatnam -530 022.

...Respondents

**Appearances:**

For the Petitioner : M/s. P.V. Giridhar, B.S. Chalam &amp; B. Ramu, Advocates

For the Respondent : M/s. Saibaba &amp; Srinivas, Advocates

**AWARD**

The Government of India, Ministry of Labour by its order No. L-29012/32/2016-IR(M) dated 21.3.2017 referred the following dispute under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal between the management of Andhra Cements Limited, Visakhapatnam and their workman. The reference is,

**SCHEDULE**

“Whether the action of the management of Andhra Cements Limited, Visakha Cement Limited, Visakha Cement Works, Jaypee Group of Company in not considering Sri Palla Demudu Babu, S/o Yerrinaidu, workman in service in contravention of Section 25 F of the Industrial Disputes Act, 1947, of else in not paying legal benefits for the past service rendered to Andhra Cement Company is legal and justified? If not, what relief the concerned workman is entitled to?”

The reference is numbered in this Tribunal as I.D. No. 8/2017 and notices were issued to the parties concerned.

2. The case stands posted for filing of claim statement by the Petitioner.

3. In spite of repeated calls, the Petitioner did not turn up. Several opportunities have been given to the Petitioner Workman to attend the court to prosecute his case. But the Petitioner workman failed to attend this Tribunal which clearly indicates that perhaps the dispute of the Petitioner workman has already been settled and the Petitioner has no claim to raise against the Respondent. Hence, the case of the Petitioner workman is closed and a ‘No dispute’ award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant, corrected by me on this the 12<sup>th</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

**Appendix of evidence**Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Petitioner**

NIL

**Documents marked for the Respondent**

NIL

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 697.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स आन्ध्र सीमेंट्स लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 29/2016) को प्रकाशित करती है जो केन्द्रीय सरकार को 06.08.2020 को प्राप्त हुआ था।

[सं. एल-29012/18/2016-आईआर(एम)]

ए. के. सिंह, अवसर सचिव

New Delhi, the 11th August, 2020

**S. O. 697.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 29/2016) of the Central Government Industrial Tribunal/Labour Court, Hyderabad now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Andhra Cements Limited, and their workman, which was received by the Central Government on 06.08.2020.

[No. L-29012/18/2016-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 3<sup>rd</sup> day of July, 2020**INDUSTRIAL DISPUTE No. 29/2016****Between:**

Sri Karaka Eswara Rao,  
S/o Sh. Ramulu,  
Village-Moglipuram,  
Sabbavaram (M),  
Distt. Visakhapatnam (A.P.)

...Petitioner

**AND**

The Senior Vice President & Plant Head,  
Andhra Cements Limited, Jaypee Group,  
Visakha Cement Works, Porlupalem (Village),  
Post – Durganagar, Visakhapatnam (A.P.) – 530 029

...Respondent

**Appearances:**

For the Petitioner : M/s. P.V. Giridhar, P.V.P.A. Harakumar & P. Annapoorna, Advocates

For the Respondent : M/s. Saibaba & Srinivas, Advocates

**AWARD**

The Government of India, Ministry of Labour by its order No. L-29012/ 18/2016-IR(M) dated 29.3.2016 referred the following dispute under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal between the management of Andhra Cements Limited and their workman. The reference is,

**SCHEDULE**

“Whether the action of the management of Andhra Cements Limited, Visakha Cement Works, Visakhapatnam, Jaypee Group of Company in not considering Sri Karaka Eswara Rao, S/o Ramulu, in services or else in not paying legal/ terminal benefits for the past services rendered to Andhra Cement Company, Visakhapatnam is legal and justified? If not, to what relief the concerned workman is entitled?”

The reference is numbered in this Tribunal as I.D. No. 29/2016 and notices were issued to the parties concerned.

2. The case stands posted for filing of claim statement by the Petitioner.

3. In spite of repeated calls, the Petitioner did not turn up. Several opportunities have been given to the Petitioner Workman to attend the court to prosecute his case. But the Petitioner workman failed to attend this Tribunal which clearly indicates that perhaps the dispute of the Petitioner workman has already been settled and the Petitioner has no claim to raise against the Respondent. Hence, the case of the Petitioner workman is closed and a ‘No dispute’ award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant, corrected by me on this the 3<sup>rd</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

**Appendix of evidence**

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Petitioner**

NIL

**Documents marked for the Respondent**

NIL

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 698.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स आन्ध्र सीमेंट्स लिमिटेड के प्रबंधन के संबंध में नियोजकों और उनके कर्मचारियों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 30/2016) को प्रकाशित करती है जो केन्द्रीय सरकार को 06.08.2020 को प्राप्त हुआ था।

[सं. एल-29012/19/2016-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 698.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 30/2016) of the Central Government Industrial Tribunal/Labour Court, Hyderabad now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Andhra Cements Limited, and their workman, which was received by the Central Government on 06.08.2020.

[No. L-29012/19/2016-IR(M)]

A. K. SINGH, Under Secy.

#### ANNEXURE

#### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 4<sup>th</sup> day of March, 2020

#### INDUSTRIAL DISPUTE No. 30/2016

#### Between:

Sri Guri Satyanaryana,  
S/o Sh. Ramu,  
Village-Moglipuram,  
Sabbavaram (M),  
Distt. Visakhapatnam (A.P.)-531035.

...Petitioner

#### AND

The Senior Vice President & Plant Head,  
Andhra Cements Limited, Jaypee Group,  
Visakha Cement Works, Porlupalem (Village),  
Post – Durganagar, Visakhapatnam (A.P.) – 530 029.

...Respondent

#### Appearances:

For the Petitioner : M/s. P. V. Giridhar, P. V. P. A. Harakumar & P. Annapoorna, Advocates

For the Respondent : M/s. Saibaba & Srinivas, Advocates

#### AWARD

The Government of India, Ministry of Labour by its order No. L-29012/ 19/2016-IR(M) dated 29.3.2016 referred the following dispute under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal between the management of Andhra Cements Limited and their workman. The reference is,

#### SCHEDULE

“Whether the action of the management of Andhra Cements Limited, Visakha Cement Works, Visakhapatnam, Jaypee Group of Company in not considering Sri Guri Satyanarayana, S/o Ramu, in services or else in not paying legal/ terminal benefits for the past services rendered to Andhra Cement Company, Visakhapatnam is legal and justified? If not, to what relief the concerned workman is entitled?”

The reference is numbered in this Tribunal as I.D. No. 30/2016 and notices were issued to the parties concerned.

2. The case stands posted for filing of claim statement by the Petitioner.

3. In spite of repeated calls, the Petitioner did not turn up. Several opportunities have been given to the Petitioner Workman to attend the court to prosecute his case. But the Petitioner workman failed to attend this Tribunal which clearly indicates that perhaps the dispute of the Petitioner workman has already been settled and the Petitioner has no claim to raise against the Respondent. Hence, the case of the Petitioner workman is closed and a ‘No dispute’ award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant, corrected by me on this the 4<sup>th</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### Appendix of evidence

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

### Documents marked for the Petitioner

NIL

### Documents marked for the Respondent

NIL

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 699.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स आन्ध्र सीमेंट्स लिमिटेड के प्रबंधन के संबंध में नियोजकों और उनके कर्मचारियों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 31/2016) को प्रकाशित करती है जो केन्द्रीय सरकार को 06.08.2020 को प्राप्त हुआ था।

[सं. एल-29012/20/2016-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 699.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the award (Ref. No. 31/2016) of the Central Government Industrial Tribunal/Labour Court, Hyderabad now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. Andhra Cements Limited, and their workman, which was received by the Central Government on 06.08.2020.

[No. L-29012/20/2016-IR(M)]

A. K. SINGH, Under Secy.

### ANNEXURE

### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 12<sup>th</sup> day of March, 2020

### INDUSTRIAL DISPUTE No. 31/2016

#### Between:

Sri Kolli Ramu Naidu,  
S/o Sh. Yerri Naidu,  
Village-Moglipuram,  
Sabbavaram (M),  
Distt. Visakhapatnam (A.P.)-531035.

...Petitioner

AND

The Senior Vice President & Plant Head,  
Andhra Cements Limited, Jaypee Group,  
Visakha Cement Works, Porlupalem (Village),  
Post – Durganagar, Visakhapatnam (A.P.) – 530 029.

...Respondent

**Appearances:**

For the Petitioner : M/s. P.V. Giridhar, P.V.P.A. Harakumar & P. Annapoorna, Advocates  
 For the Respondent : M/s. Saibaba & Srinivas, Advocates

**AWARD**

The Government of India, Ministry of Labour by its order No. L-29012/ 20/2016-IR(M) dated 29.3.2016 referred the following dispute under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal between the management of Andhra Cements Limited, Visakhapatnam and their workman. The reference is,

**SCHEDULE**

“Whether the action of the management of Andhra Cements Limited, Visakha Cement Works, Jaypee Group of Company in not considering Sri Kolli Ramu Naidu, S/o Yerri Naidu, in services in contravention of Section 25 F of the Industrial Disputes Act, 1947, or else in not paying legal benefits for the past services rendered to Andhra Cement Company is legal and justified? If not, to what relief the concerned workman is entitled?”

The reference is numbered in this Tribunal as I.D. No. 31/2016 and notices were issued to the parties concerned.

2. The case stands posted for filing of claim statement by the Petitioner.

3. In spite of repeated calls, the Petitioner did not turn up. Several opportunities have been given to the Petitioner Workman to attend the court to prosecute his case. But the Petitioner workman failed to attend this Tribunal which clearly indicates that perhaps the dispute of the Petitioner workman has already been settled and the Petitioner has no claim to raise against the Respondent. Hence, the case of the Petitioner workman is closed and a ‘No dispute’ award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant, corrected by me on this the 12<sup>th</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

**Appendix of evidence**

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Petitioner**

NIL

**Documents marked for the Respondent**

NIL

नई दिल्ली, 11 अगस्त, 2020

**का.आ.700.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स ईएसआईसी अस्पताल एवं अन्य के प्रबंधन के संबंध में नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय-2, चंडीगढ़ के पंचाट (संदर्भ संख्या 5/2019) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-15012/4/2019-आईआर(एम)]

ए. के. सिंह, अवर सचिव



New Delhi, the 11th August, 2020

**S.O. 700.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 5/2019) of the Central Government Industrial Tribunal/Labour Court-2, Chandigarh now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. ESIC Hospital and other, and their workman, which was received by the Central Government on 05.08.2020.

[No. L-15012/4/2019-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE**

**IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT-II,  
CHANDIGARH**

**Present:** Sh. A.K. Singh, Presiding Officer

**ID No. 5/2019**

Registered on:-02.04.2019

Swantantar Kumar, C/o Near Gurdwara, Teli Basti,  
Bari Brahmana, Jammu (J&K)-181133.

...Workman

**Versus**

1. The Medical Superintendent, ESIC Hospital, Bari Brahmana, District-Samba (J&K).
2. Col. Bhupinder Singh Samyal, House No.G-60,  
Sainik Colony, Jammy (J&K).

...Respondents/Managements

**AWARD**

**Passed on:-02.03.2020**

Central Government vide Notification No. L-15012/4/2019-IR(M) Dated 25.02.2019, under clause (d) of sub-section (1) and sub-section (2A) of Section 10 of the Industrial Disputes Act, 1947(hereinafter called the Act), has referred the following Industrial dispute for adjudication to this Tribunal:-

**“Whether the action of Col. Bhupinder Singh Samyal, House No.G-60, Sainik Colony, Jammu(J&K) as contractor under ESIC Hospital, Bari Brahmana, District Samba (J&K) in terminating the services of Shri Swantantar Kumar w.e.f. 10.05.2018 is proper, legal and justified? If not, to what relief the disputant is entitled to and from which date?”**

1. On the receipt of the above reference, notice was sent to the workman as well as the managements/respondents. The postal article sent to the workman, referred above, is duly delivered to the workman. Workman is given sufficient opportunity to file claim statement but none turned up in spite of the opportunity afforded to file claim statement, which shows that the workman is not interested in adjudication of the matter on merit.

2. Since the workman has neither put his appearance nor has he led any evidence so as to prove his cause against the managements/respondents, as such, this Tribunal is left with no choice, except to pass a ‘No Dispute Award/No Claim Award’. It is also clarified that passing of the no dispute award/no claim award would not bar the workman from approaching the Appropriate Government/this Tribunal for adjudication of this case on merits or filing any fresh claim. Let copy of this award be sent to the Appropriate Government as required under Section 17 of the Act for publication.

A. K. SINGH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 701.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स ईएसआईसी अस्पताल एवं अन्य के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण एवं श्रम न्यायालय-2, चंडीगढ़ के पंचाट (संदर्भ संख्या 7/2019) को प्रकाशित करती है जो केन्द्रीय सरकार को 05.08.2020 को प्राप्त हुआ था।

[सं. एल-15012/5/2019-आईआर(एम)]

ए. के. सिंह, अवसर सचिव

New Delhi, the 11th August, 2020

**S. O. 701.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 7/2019) of the Central Government Industrial Tribunal/Labour Court-2, Chandigarh now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. ESIC Hospital and other, and their workman, which was received by the Central Government on 05.08.2020.

[No. L-15012/5/2019-IR(M)]

A. K. SINGH, Under Secy.

**ANNEXURE**

**IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT-II,  
CHANDIGARH**

**Present:** Sh. A.K. Singh, Presiding Officer

**ID No.7/2019**

Registered on:-02.04.2019

Mohinder Prakash, Ex-Sobidar, R/o Indra Nagar,  
Post Office Miran Sahib, Tehsil R.S. Pura, Jammu(J&K).

... Workman

**Versus**

1. The Medical Superintendent, ESIC Hospital, Bari Brahmana, District-Samba (J&K).

2. Col. Bhupinder Singh Samyal, House No.G-60,  
Sainin Colony, Jammy(J&K).

... Respondents/Managements

**AWARD**

**Passed on:-02.03.2020**

Central Government vide Notification No. L-15012/5/2019-IR(M) Dated 25.02.2019, under clause (d) of sub-section (1) and sub-section (2A) of Section 10 of the Industrial Disputes Act, 1947(hereinafter called the Act), has referred the following Industrial dispute for adjudication to this Tribunal:-

**“Whether the action of Col. Bhupinder Singh Samyal, House No.G-60, Sainik Colony, Jammu(J&K), contractor under the Management of ESIC Hospital, Bari Brahmana, District Samba(J&K) in terminating the services of Shri Mohinder Prakash w.e.f. 31.03.2018 in reference to Routine Transfer letter dated 16.03.2018 is legal, proper and justified? If not, to what relief the disputed is entitled to and from which date?”**

1. On the receipt of the above reference, notice was sent to the workman as well as the managements/respondents. The postal article sent to the workman, referred above, is duly delivered to the workman. Workman is given sufficient opportunity to file claim statement but none turned up in spite of the opportunity afforded to file claim statement, which shows that the workman is not interested in adjudication of the matter on merit.

2. Since the workman has neither put his appearance nor has he led any evidence so as to prove his cause against the managements/respondents, as such, this Tribunal is left with no choice, except to pass a ‘No Dispute Award/No Claim Award’. It is also clarified that passing of the no dispute award/no claim award would not bar the workman from approaching the Appropriate Government/this Tribunal for adjudication of this case on merits or filing any fresh claim. Let copy of this award be sent to the Appropriate Government as required under Section 17 of the Act for publication.

A. K. SINGH, Presiding Officer

नई दिल्ली, 11 अगस्त, 2020

**का.आ. 702.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार मैसर्स ए.ए.सी. माईनिंग एक्सक्यूटर इंडिया प्रा. लिमिटेड एवं अन्य के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में औद्योगिक अधिकरण/श्रम न्यायालय, भीलवाड़ा के पंचाट (संदर्भ संख्या 9/2018) को प्रकाशित करती है जो केन्द्रीय सरकार को 04.08.2020 को प्राप्त हुआ था।

[सं. जेड-16025/4/2020-आईआर(एम)]

ए. के. सिंह, अवर सचिव

New Delhi, the 11th August, 2020

**S. O. 702.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 9/2018) of the Industrial Tribunal/Labour Court, Bhilwara now as shown in the Annexure in the Industrial Dispute between the employers in relation to the management of M/s. A.A.C. Mining Executer India Pvt. Ltd. and other, and their workman, which was received by the Central Government on 04.08.2020.

[No. Z-16025/4/2020-IR(M)]

A. K. SINGH, Under Secy.

### अनुबंध

### श्रम न्यायालय, भीलवाड़ा

**पीठासीन अधिकारी:** श्री अजीत कुमार हिंगर, आर.जे.एस. (जिला न्यायाधीश संवर्ग)

**प्रकरण संख्या : 9 सन् 2018**

श्री दिनेश कुमार शर्मा पुत्र श्री भैरूलाल शर्मा,  
नि.— ग्राम पो.—हुरडा, जिला— भीलवाड़ा।

...प्रार्थी

### बनाम

1. प्रबंधक, ए.ए.सी. माईनिंग एक्सक्यूटर इंडिया प्रा. लि.,  
रामपुरा— आगूंचा खान, जिला— भीलवाड़ा।
2. प्रबंधक, हिन्दुस्तान ज़िंक लि., रामपुरा—आगूंचा खान,  
जिला— भीलवाड़ा

...विपक्षीगण

### उपस्थित

श्री सत्यनारायण शर्मा, प्रतिनिधि—प्रार्थी की ओर से।

श्री प्रदीप कुमार चतुर्वेदी, प्रतिनिधि—विपक्षी सं० एक की ओर से।

श्री आर.सी.चेचाणी, अधिवक्ता— विपक्षी सं० दो की ओर से।

### :: पंचाट ::

दिनांक : 6.3.2020

1. प्रार्थी श्रमिक ने विपक्षी के विरुद्ध सेवा पृथक्करण बाबत अपना विवाद सुलह अधिकारी एवं सहायक श्रम आयुक्त (केन्द्रीय), अजमेर के समक्ष पेश किया, जहां 45 दिन की समयावधि में कोई समझौता नहीं होने के कारण प्रार्थी ने औद्योगिक विवाद अधिनियम 1947 (जिसे पंचाट में आगे अधि० 1947 से सम्बोधित किया जायेगा) की धारा 2 (ए) के तहत यह विवाद न्यायालय के समक्ष पेश किया।

2. प्रार्थी की ओर से क्लेम प्रार्थना पत्र में यह अंकित किया गया है कि उसे विपक्षी सं० एक ने दिनांक 12.9.2014 को इलेक्ट्रीशियन हेल्पर के पद पर नियोजित किया। उसका नियोजन अधि० 1947 की धारा 25—बी के तहत नियमित नियोजन की तारीफ में आता है। सेवाकाल में घटित दुर्घटना दिनांक 20.12.2014 के उपचार में हुए व्यय के बिलों का भुगतान विपक्षीगण द्वारा बार— बार निवेदन करने पर भी नहीं किया गया। सदैव की भांति वह दिनांक 18.5.2016 को कार्य पर उपस्थित हुआ तो उसे बिना किसी लिखित सूचना के एच.आर.हैड श्री प्रदीप कुमार चतुर्वेदी ने काम पर लेने से इंकार कर दिया। उसका सेवा पृथक्करण अवैध है। प्रार्थी ने समस्त वेतन परिलाभों सहित पुनः सेवा में नियोजित करवाने का निवेदन किया।

3. विपक्षी सं. एक की ओर से जवाब पेश कर प्रारंभिक आपत्ति के रूप में जाहिर किया गया कि प्रार्थी को सेवा पृथक नहीं किया गया है अपितु वह स्वयं ही ड्यूटी से अनुपस्थित रहा है। उत्तरदाता कं. के नियमों के तहत यदि उसे सेवा पृथक किया जाता है तो वह 30 दिन की अवधि में अपीलांत अधिकारी के समक्ष अपील प्रस्तुत कर सकता है। उत्तरदाता विपक्षी सं. दो के यहां संविदाकार के रूप में कार्यरत है। प्रार्थी के अनुपस्थित होने से उसके स्थान पर अन्य को कार्य पर रखना पड़ा तथा उसे अधिश्रम का भुगतान भी करना पड़ा, जिससे कंपनी को आर्थिक हानि हुई। बिन्दुवार जवाब प्रस्तुत करते हुए जाहिर किया गया कि प्रार्थी उनके यहां सेवारत था, अतः उसके समस्त भुगतान का दायित्व उत्तरदाता का है। प्रार्थी को वर्ष 2014 में 650 रु. मासिक चिकित्सा भत्ता का भुगतान किया जाता था इसके बावजूद भी प्रार्थी का स्वास्थ्य ड्यूटी के दौरान खराब होने से उसका इलाज जिक अस्पताल व रामस्नेही अस्पताल, भीलवाड़ा में कराया गया तथा इलाज में हुए व्यय का भुगतान उत्तरदाता द्वारा ही किया गया। प्रार्थी को चिकित्सक द्वारा दिनांक 27.1.2014 को ड्यूटी के लिए योग्य घोषित किया गया, अतः प्रार्थी का कोई क्लेम बकाया नहीं है। प्रार्थी को कंपनी सेवा से पृथक नहीं किया गया, अतः वह ड्यूटी पर उपस्थित होने के लिए स्वतंत्र था, लेकिन वह स्वयं ही ड्यूटी पर उपस्थित नहीं हुआ। उसका कृत्य स्वैच्छा से सेवाओं का परित्याग की श्रेणी में आता है। क्लेम प्रार्थना पत्र खारिज करने की प्रार्थना की गई।

4. विपक्षी सं. दो की ओर से जवाब पेश कर जाहिर किया गया कि प्रार्थी कभी भी उत्तरदाता का कर्मचारी नहीं रहा है। इस मामले से उत्तरदाता का कोई संबंध नहीं है। क्लेम प्रार्थना पत्र खारिज करने की प्रार्थना की गई।

5. प्रार्थी की ओर से साक्ष्य में ए ड 1 दिनेश कुमार शर्मा के शपथपत्र पर बयान दर्ज करवाये गये तथा बतौर प्रलेखीय साक्ष्य प्रदर्श 1 रामस्नेही अस्पताल की उपचार पर्ची, प्रदर्श 2 प्रार्थी द्वारा उपचार में हुए व्यय की राशि के भुगतान के संबंध में विपक्षी सं० एक को लिखा पत्र दिनांक 5.2.2015, प्रदर्श 3 प्रार्थी द्वारा उपचार में हुए व्यय की राशि के भुगतान के संबंध में विपक्षी सं० एक को लिखा पत्र दिनांक 10.4.2015, प्रदर्श 4 जिक हॉस्पिटल की उपचार पर्ची दिनांक 17.5.2016, प्रदर्श 5 मित्तल हॉस्पिटल का सूचनापत्र दिनांक 18.5.2016, प्रदर्श 6 मित्तल हॉस्पिटल की जांच रिपोर्ट दिनांक 18.5.2016, प्रदर्श 7 प्रार्थी द्वारा सेवा में लेने के संबंध में दिया गया पत्र दिनांक 6.6.2016, प्रदर्श 8 प्रार्थी द्वारा सेवा में लेने के संबंध में दिया गया पत्र दिनांक 23.6.2016 को प्रदर्शित कराया गया।

6. विपक्षी की ओर से साक्ष्य में एन ए ड 1 जयंत त्रिवेदी व एन ए ड 2 अंकित जोशी के बयान शपथ पत्र पर दर्ज कराये गये तथा प्रदर्श एम 1 से प्रदर्श एम 3 विपक्षी का फार्म—सी माह अप्रैल 2016 से जून 2016, प्रदर्श एम 4 वेतन स्लीप माह मई 2016, प्रदर्श एम 5 बैंक स्टेटमेंट, प्रदर्श एम 6, 7 व 8 बीमा पॉलिसी को प्रदर्शित करवाया गया।

7. हमने संपूर्ण पत्रावली का अध्ययन किया। विचार . किया। विचारणीय बिन्दु अग्रलिखित है—

क्या प्रार्थी व विपक्षीगण के मध्य श्रमिक—नियोजक के संबंध रहे हैं? यदि हां, तो क्या उसे दिनांक 18.5.2016 से विपक्षी ने अवैध तौर पर सेवा से पृथक कर दिया? यदि हां, तो वह क्या अनुतोष प्राप्त करने का अधिकारी है एवं क्या प्रार्थी, विपक्षी से चिकित्सा मद की कोई राशि भी प्राप्त करने का अधिकारी है।

8. साक्ष्य में प्रार्थी दिनेश कुमार शर्मा ने मुख्य परीक्षण स्वरूप शपथ पत्र में अंकित किया है कि विपक्षी सं. एक ए. ए.सी. माईनिंग एक्सक्यूटर इंडिया प्रा.लि. को हिन्दुस्तान जिक लि. ने खनन कार्य का ठेका दे रखा है। वह विपक्षी सं० एक के अधीन विद्युत विभाग में इलेक्ट्रीशियन हेल्पर के पद पर दिनांक 12.9.2014 को नियुक्त किया गया, वहां उसकी सेवाएं नियमित रूप से चलती रही। सेवाकाल के दौरान दिनांक 20.12.2014 को वह दुर्घटनाग्रस्त हुआ और इस कारण दिनांक 20.12.2014 से 21.1.2015 तक दुर्घटना अवकाश पर रहा, फिर दिनांक 27.1.2015 को सेवा देने के लिए विपक्षी के समक्ष उपस्थित हुआ, लेकिन चिकित्साधिकारी के निर्देशानुसार उसे हल्का कार्य नहीं दिया गया वरन् पूर्ववत् ही कार्य करवाया जाता रहा। उसे उपचार का खर्चा भी नहीं दिया गया। सेवाकाल के दौरान पुनः 16.5.2016 को वह पहली पाली में बेहोश हो गया। उसे प्राज्ञ कुंदन चिकित्सालय, बिजयनगर में भर्ती कराया गया और फिर अजमेर स्थित मित्तल हॉस्पिटल में जांच हेतु रेफर कर दिया गया। जांचों में हुए खर्च का भुगतान भी उसे नहीं किया गया। वह उपचार मद की राशि प्राप्त करने का अधिकारी है। वह दिनांक 18.5.2016 को सेवा देने हेतु उपस्थित हुआ तो विपक्षी ने उसे सेवा में नहीं आने दिया। इस संबंध में उसने अथक प्रयास किये, लेकिन उसे अवैधानिक तरीके से सेवा से वंचित रखा जाता रहा और उससे कनिष्ठ सहकर्मियों की सेवाएं ली जाती रही। वह दिनांक 18.5.2016 से ही पूर्ण वेतन, वरियता एवं समस्त सेवा लाभों सहित पुनः पदस्थापित होने का अधिकारी है। जिरह में गवाह का कथन है कि यह सही है कि मुझे कार्य करने के लिए भूमिगत खदान में जाना पड़ता था। जोईनिंग के समय मुझे 12,700 रु. व फिर लास्टमें 28,700 रु. मासिक वेतन मिलता था। प्रदर्श 1 रामस्नेही चिकित्सालय का है, जहां मुझे कंपनी के द्वारा भेजा गया था। रामस्नेही चिकित्सालय के 6200 रु. के बिल बने थे, जिसमें से कंपनी ने 500 रु. मुझे कैश दिये थे, बाकी की राशि का भुगतान मैंने ही किया था। बिलों की फोटो प्रतियां पेश की, उनकी प्राप्ति रसीद मेरे पास नहीं है अज खुद कहा कि रसीद देते ही नहीं है। यह सही है कि प्रदर्श 2 में बिल की राशि व बिल के नंबर का उल्लेख नहीं है। प्रदर्श 3 में भी बिल की राशि व बिल के नंबर का उल्लेख नहीं किया था। मैं दिनांक 18.5.2016 के बाद प्रतिदिन पोर्टल पर ड्यूटी के लिए उपस्थित होता था, लेकिन मुझे वहां से एच.आर. में भेजा गया। यह सही है कि दिनांक 18.5.2016 के बाद मेरी उपस्थिति दर्ज नहीं है अज खुद कहा कि मैं तो ड्यूटी पर उपस्थित होता रहा था। यह सही है कि मुझे खदान में प्रवेश के लिए गेट पर पंचिंग करके ही अंदर आना था। आगे विपक्षी सं० दो की ओर से की गई जिरह में गवाह का यह भी कहना है कि यह सही है कि हॉस्पिटल व्यय व वेतन संबंधी मुझे जितना भी भुगतान हुआ वह मुझे विपक्षी सं. एक ने किया है। यह सही है कि इस प्रकरण से संबंधित मेरा विवाद विपक्षी सं० एक के साथ है।

9. इसके विपरीत विपक्षी के गवाह एन ए ड 1 जयंत त्रिवेदी ने मुख्य परीक्षण स्वरूप शपथपत्र में अंकित किया है कि वह विपक्षी सं. एक ए.ए.सी. माईनिंग में वर्ष 2013 से कार्यरत है और वर्तमान में उपप्रबंधक, एच.आर. के पद पर कार्य कर रहा है। वह कर्मचारियों की भर्ती, चयन वेतन निर्धारण, वार्षिक वेतन वृद्धि, पदोन्नति, अनुशासनात्मक कार्यवाही एवं अन्य नियोजन संबंधी कार्य संपादित कर रहा है। दिनेश कुमार शर्मा, प्रार्थी को कभी प्रबंधक द्वारा दंडित नहीं किया गया, न ही उसके विरुद्ध अनुशासनात्मक कार्यवाही अमल में लाई गई वरन् वह दिनांक 27.5.2016 के उपरांत ड्यूटी पर उपस्थित नहीं हुआ। किसी कर्मचारी की यदि कार्य के दौरान दुर्घटना हो जाती है तो कामगार क्षतिपूर्ति अधि० के तहत उसे क्षतिपूर्ति का भुगतान किया जाना सुनिश्चित किया जाता है। दिनांक 20.12.2014 को कार्य के दौरान चोट लगने पर उसका पहले हिन्दुस्तान जिक लि. के चिकित्साधिकारी व फिर भीलवाड़ा स्थित रामस्नेही चिकित्सालय में उपचार करवाया गया। विपक्षी सं० एक ने उपचार के संबंध में हुए समस्त खर्चों को वहन किया। दिनांक 17.5.2016 को उसने जिक हॉस्पिटल के चिकित्साधिकारी को चेकअप अर्द्धचेतना के लिए करवाया था, लेकिन कार्य के दौरान माईन्स में दुर्घटना का केस नहीं होने के कारण कंपनी को इनके चिकित्सा उपचार की जानकारी नहीं है। जिरह में गवाह का कथन है कि यह कहना गलत है कि दिनांक 20.12.2014 को सेवा के दौरान प्रार्थी का कोई एक्सीडेंट हुआ हो अज खुद कहा कि प्रार्थी अस्वस्थ हुआ था और वह अनकॉशियस हो गया था। दिनांक 16.5.12.2016 को भी प्रार्थी कार्य के दौरान प्रातः 7.15 पर बेहोश हुआ हो तो मुझे जानकारी नहीं है। प्रदर्श 7 व 8 पत्र हमें प्राप्त नहीं हुआ। हमने प्रार्थी को काम पर उपस्थित होने के लिए कोई पत्र नहीं लिखा अज खुद कहा कि हमारी सामान्य प्रक्रिया के अनुसार किसी कार्मिक के अनुपस्थित होने पर हम दूसरे को रख लेते हैं। रामस्नेही अस्पताल में भर्ती रहने पर चिकित्सक ने प्रार्थी को हल्का कार्य देने हेतु कहा हो तो मुझे जानकारी नहीं है। यह कहना गलत है कि चिकित्सक की उक्त सलाह के बावजूद हमने उसे भारी काम दिया हो और इस कारण वह त्यागपत्र देने को मजबूर हुआ हो अज खुद कहा कि हमारे यहां सभी कार्य भूमिगत ही है। विपक्षी सं० दो की ओर से की गई जिरह में गवाह का कथन है कि यह सही है कि मैंने बयानों में कंपनी व संस्थान शब्द काम में लिए हैं, जिनसे मेरा आशय ए ए सी माईनिंग विपक्षी सं० एक से है।

10. विपक्षी के गवाह एन ए ड 2 अंकित जोशी ने मुख्य परीक्षण स्वरूप शपथपत्र में अंकित किया है कि वह विपक्षी सं० एक के यहां वर्ष 2012 से कार्यरत है और एच.आर. विभाग में कार्य करता है। भूमिगत खान में कार्य पर जाने वाले कर्मचारियों द्वारा भूमिगत खदान पोर्टल पर गेट चेकर के यहां से वापस सतह पर आने पर गेट चेकर से यूजी टोकन प्राप्त किया जाता है। गेट चेकर द्वारा खान विनियम के तहत रखे जाने वाले फार्म –सी में कर्मचारियों के खान में जाने एवं वापस आने के समय का इन्द्राज किया जाता है तथा कर्मचारियों की पाली अनुसार उपस्थिति की सूचना एच.आर. विभाग में भिजवाई जाती है। प्रार्थी की उपस्थिति अंतिम बार दिनांक 27.5.2016 को प्राप्त हुई। सत्यापन के बाद उसे मई 2016 के उपस्थिति के दिनों का भुगतान नियमानुसार कर दिया गया। जिरह में गवाह का कथन है कि प्रदर्श 6 व 7 हमें नहीं मिले थे।

11. बहस के दौरान प्रार्थी प्रतिनिधि ने प्रार्थना पत्र में उल्लेखित तथ्यों को दोहराया और लिखित बहस भी पेश की। विपक्षी सं० एक के प्रतिनिधि ने यह कथन किया कि प्रार्थी ने विचाराधीन प्रार्थनापत्र के जरिये ईलाज खर्च की बकाया राशि की मांग की है, जो वह इस प्रकरण में प्राप्त नहीं कर सकता। इस राशि की मांग हेतु उसे कर्मचारी क्षतिपूर्ति अधि० के तहत कार्यवाही करनी चाहिये थी। जहां तक अवैध सेवा पृथक्करण का प्रश्न है, उनकी यह दलील रही है कि स्वयं प्रार्थी ने दिनांक 27.5.2016 तक विपक्षी के यहां कार्य किया है, अतः उसके द्वारा बताये गये तथ्य सही नहीं हैं, इस कारण इस संबंध में भी उसकी मांग स्वीकार योग्य नहीं है। विपक्षी सं० एक की ओर से भी लिखित बहस पेश की गई। विपक्षी सं० दो की ओर से यह दलील रखी गई कि उनके व प्रार्थी के मध्य नियोजक—श्रमिक के संबंध नहीं रहे, अतः प्रार्थी उनसे कोई अनुतोष प्राप्त करने का अधिकारी नहीं है।

12. हमने संपूर्ण पत्रावली का अध्ययन किया और दोनों पक्षों को सुना एवं विचार किया।

13. स्वयं प्रार्थी ने अपने क्लेम प्रार्थना पत्र में यह अंकित किया है कि वह विपक्षी सं. एक के अधीन इलेक्ट्रीशियन हेल्पर के पद पर दिनांक 12.9.2014 को नियुक्त किया गया था। इस संबंध में विपक्षी सं. एक ने भी अपने जवाब में प्रार्थी का उसके अधीन सेवारत होना और भुगतान का दायित्व भी उसी का होना स्वीकार किया है। इस प्रकार यह स्पष्ट है कि प्रार्थी को विपक्षी सं. एक ने ही नियोजन में लिया तथा भुगतान भी वे ही करते रहे। विपक्षी सं. एक ने हमारे समक्ष उसके और विपक्षी सं. दो के मध्य निष्पादित संविदा की प्रति भी पेश की है, जिससे यह स्पष्ट है कि विपक्षी सं. दो ने विपक्षी सं. एक को भूमिगत कार्य हेतु टेका दिया। समग्र साक्ष्य से यह स्पष्ट है कि प्रार्थी व विपक्षी सं. एक के मध्य श्रमिक—नियोजक के संबंध रहे हैं।

14. प्रार्थी ने अपनी नियुक्ति दिनांक 12.9.2014 को होना बताया है, जिसे विपक्षी ने भी स्वीकार किया है। इसके बाद दिनांक 20.12.2014 को प्रार्थी का नियोजन के दौरान दुर्घटनाग्रस्त/चोटग्रस्त होने का जो कथन प्रार्थी ने किया है, उसे विपक्षी सं० एक ने भी स्वीकार किया है। दोनों पक्षों के अभिवचनों व साक्ष्य से यह प्रकट हुआ है कि इस दुर्घटना के संबंध में हुए ईलाज के खर्च को लेकर भी दोनों पक्षों के मध्य विवाद विद्यमान है। एक ओर जहां प्रार्थी का यह कहना है कि दुर्घटना का पूरा खर्चा विपक्षी ने नहीं दिया वहीं दूसरी ओर विपक्षी ने यह बताया है कि इस दुर्घटना के पश्चात् प्रार्थी को पहले उनके ट्रांसपोर्ट के माध्यम से जिक चिकित्सालय भेजा गया और फिर भीलवाड़ा स्थित रामस्नेही चिकित्सालय में एम्बुलेंस की व्यवस्था कर उसे भेजा गया तथा रामस्नेही चिकित्सालय में हुए कुल खर्च की राशि 5720 रु. का भुगतान भी उन्हीं के द्वारा किया गया। इस संबंध में हालांकि प्रार्थी ने विपक्षी को विभिन्न पत्र शेष भुगतान हेतु लिखा जाना कहा है और इन पत्रों की प्रतियां प्रदर्श 2 व 3 भी हमारे समक्ष पेश की हैं, लेकिन इन पत्रों में विपक्षी के जिम्मे कुल कितनी उपचार राशि बकाया है, इसका कोई उल्लेख नहीं है, अतः प्रार्थी की साक्ष्य से यह स्पष्ट नहीं हो पा रहा है कि दिनांक



20.12.2014 के उपचार की कितनी राशि विपक्षी द्वारा दिया जाना अपेक्षित है, अतः इस बाबत कोई निर्धारण किया जाना संभव नहीं है।

15. अब प्रश्न यह है कि क्या विपक्षी ने प्रार्थी को दिनांक 18.5.2016 से कार्य पर नहीं लिया एवं क्या उसे अवैध तौर पर सेवा पृथक कर दिया?

16. इस संबंध में साक्ष्य में प्रार्थी ने यह अंकित किया है कि वह दिनांक 16.5.2016 को कार्य के दौरान प्रथम पाली में प्रातः करीब 7.15 बजे बेहोश हो गया था तब उसे विपक्षीगण ने प्राज्ञ कुंदन चिकित्सालय में भर्ती करवाया था, जहां से उसे अजमेर स्थित मित्तल हॉस्पिटल में जांच कराने हेतु रेफर कर दिया गया। इस संबंध में विपक्षी सं० एक के गवाह जयंत त्रिवेदी के शपथपत्र के पैरा सं० 6 में अग्रलिखित अंकन किया गया है—

*“यह कि श्री दिनेश कुमार शर्मा द्वारा दिनांक 17.5.2016 को स्वयं जिन हॉस्पिटल रामपुरा-आगूचा खान चिकित्साधिकारी को अपना चेकअप अचानक अर्द्धचेतना के लिए कराया गया, कार्य के दौरान माईन एक्सीडेंट के फलस्वरूप चोट लगने का केस नहीं होने से कंपनी को इनके चिकित्सा उपचार संबंधित कोई जानकारी नहीं है।”*

17. उक्त अंकन से यह प्रकट होता है कि प्रार्थी द्वारा दिनांक 17.5.2016 को जिन अस्पताल में अर्द्धचेतना के लिए अपने चेकअप कराये जाने के तथ्य की विपक्षी को जानकारी तो है, लेकिन उनका यह कहना है कि प्रार्थी ने यह जांच माईन में दुर्घटना के फलस्वरूप चोट लगने के कारण नहीं करवाई थी, अतः विपक्षी कंपनी को इस चिकित्सा उपचार की कोई जानकारी नहीं है। अर्थात् दिनांक 17.5.2016 को हुई जांच को वे उसके नियोजन से संबंधित नहीं होना बता रहे हैं, लेकिन इतना तो स्पष्ट ही है कि प्रार्थी के अस्वस्थ होने की जानकारी तो विपक्षी को थी ही।

18. दिनांक 18.5.2016 को उसे कार्य पर नहीं लेने का जो कथन प्रार्थी ने किया है, उसका विपक्षी ने यह कहते हुए खंडन किया है कि स्वयं प्रार्थी ही इस तिथि को कार्य पर उपस्थित नहीं आया था। उन्होंने प्रार्थी को कभी सेवा पृथक नहीं किया। यदि विपक्षी की इस दलील को सही माने तो भी अनुपस्थिति की स्थिति में विपक्षी से यह अपेक्षित था कि वे प्रार्थी को पत्र जारी कर उपस्थिति हेतु कहते या निरंतर अनुपस्थिति की स्थिति में उसके विरुद्ध घरेलू जांच कार्यवाही करते। विपक्षी ने ऐसा कुछ नहीं किया। इससे यही प्रकट होता है कि निश्चित ही प्रार्थी को विपक्षी ने ही कार्य पर नहीं लिया।

19. मान. उच्चतम न्यायालय की नजीर एफ एल आर 1993 (67) डी.के.यादव बनाम जे.एम.ए इंडस्ट्रीज पेज 111 (तीन सदस्यीय पीठ) में यह प्रतिपादित किया गया है कि किसी कार्मिक के नियोजन का अंत करने से पहले उसे सुनकर घरेलू जांच कार्यवाही की जानी चाहिये। यदि ऐसा नहीं किया जाता है तो यह कार्मिक के अधिकारों का गंभीर हनन है। उक्त नजीर का प्रतिपादन इस प्रकार है—

Termination-Termination of service-Absence from duty-Standing Order Cl. 13(2) (iv) provides for automatic loss of lien-Service terminated-Without any enquiry and opportunity of hearing-Principles of natural justice violated-Requirement of Article 14 must be fulfilled before depriving one of livelihood-Order of termination liable to be set aside-Constitution of India 1950-Articles 14 and 21.

20. ऐसी स्थिति में विपक्षी द्वारा घरेलू जांच किये बिना सेवा पृथक किया जाना विधि सम्मत प्रतीत नहीं होता।

21. विपक्षी का यह कहना है कि प्रार्थी दिनांक 27.5.2016 को ड्यूटी पर उपस्थित हुआ था। हमारे समक्ष विपक्षी ने प्रार्थी को मई 2016 की हाजरी का विवरण पेश किया है, जिसके अनुसार वह मई माह में 7 दिवस कार्य पर उपस्थित हुआ तथा उसका अंतिम कार्य दिवस दिनांक 27.5.2016 था। इस संबंध में उनके द्वारा जो विवरण पेश किया गया है, उसके अनुसार वह मई माह में 1,2,3,4, 12, 16 व 27 तारीख को उपस्थित था। स्वयं प्रार्थी भी 17 तारीख तक की उपस्थिति तो स्वीकार कर रहा है, लेकिन उसका यह कहना है कि इसके बाद उसे दिनांक 18.5.2016 से कार्य पर नहीं लिया गया। हमारी राय में प्रार्थी का कथन विश्वसनीय है। विपक्षी ने दिनांक 27.5.2016 की प्रार्थी की उपस्थिति के संबंध में जो हाजरी पत्रक पेश किया है, उस पर प्रार्थी के कहीं हस्ताक्षर नहीं है। अतः वह दिनांक 27.5.2016 को कार्य पर उपस्थित हुआ हो, ऐसा प्रकट नहीं होता। एक बार को तर्क के लिए हम यह मान भी लें कि दिनांक 18.5.2016 से स्वयं प्रार्थी ही कार्य पर उपस्थित नहीं हुआ था तो निश्चित ही ऐसी स्थिति में विपक्षी से यह अपेक्षित था कि वे विधि सम्मत तरीके से घरेलू जांच कार्यवाही अमल में लाते। पूर्व उल्लेखित नजीर के परिपेक्ष्य में बिना जांच कार्यवाही किये उसे सेवा पृथक करना विधि सम्मत नहीं माना जा सकता।

22. प्रार्थी का नियोजन विपक्षी के यहां दिनांक 12.9.2014 से 17.5.2016 तक तो नियमित रहा ही है, इस संबंध में विपक्षी ने कोई अन्यथा स्थिति नहीं बताई है वरन् इस अवधि का नियोजन स्वीकार किया है। अतः प्रार्थी का नियोजन विपक्षी के यहां नियमित नियोजन रहा होना प्रकट होता है। समग्र विवेचन के परिपेक्ष्य में हम यह पाते हैं कि उसे दिनांक 18.5.2016 से अवैध तौर पर सेवा पृथक किया गया।

23. अब प्रश्न यह है कि प्रार्थी क्या अनुतोष प्राप्त करने का अधिकारी है? दोनों पक्षों के अभिवचनों व साक्ष्य से यह बिल्कुल स्पष्ट है कि प्रार्थी दिनांक 12.9.2014 से दिनांक 17.5.2016 तक के नियोजन काल में दिनांक 20.12.2014 को नियोजन स्थल पर दुर्घटनाग्रस्त हुआ। इसके बाद प्रार्थी दिनांक 16.5.2016 को भी स्वयं का बीमार होना बता रहा है। विपक्षी के गवाह एन ए ड 1 जयंत त्रिवेदी द्वारा शपथपत्र में किये गये अंकन से यह प्रकट होता है कि



दिनांक 17.5.2016 को भी प्रार्थी ने अर्द्धचेतना के कारण चिकित्साधिकारी को दिखाया था। हालांकि विपक्षी का यह कहना है कि इस स्थिति को कार्य के दौरान हुई दुर्घटना से जोड़कर नहीं देखा जा सकता, लेकिन सारी परिस्थितियां यह बता रही हैं कि प्रार्थी अब आगे गहरी खदान के बजाय अन्यत्र हल्के कार्य की मांग कर रहा है। स्वयं प्रार्थी ने विपक्षी को यह सुझाव दिया कि चिकित्सक की सलाह के बावजूद उसे भारी कार्य दिया जा रहा है। अतः यह प्रकट होता है कि प्रार्थी अब गहरी खदान में शारीरिक कारण से कार्य करना नहीं चाहता। इस संबंध में विपक्षी का यह कहना है कि उनके यहां भूमि के नीचे ही सारे कार्य होते हैं। विपक्षी की ओर से जो विपक्षी सं. एक व दो के मध्य हुई संविदा की प्रति पेश की गई है, उसके अवलोकन से भी यह प्रकट होता है कि विपक्षी सं. एक को भूमि के नीचे ही खदान संबंधी कार्य दिया गया। समग्र रूप से देखे तो प्रार्थी जो स्थिति बता रहा है, उसके अनुसार अब उसका विपक्षी के यहां कार्य करने की स्थिति प्रकट नहीं होती। वह जब अपनी शारीरिक स्थिति के कारण खदान में नीचे कार्य करने हेतु स्वयं को कमजोर या अक्षम पा रहा है तो उसके पुनर्नियोजन का आदेश देना उचित नहीं होगा। सारी परिस्थितियों को देखते हुए उसे अवैध सेवा मुक्ति की एवज में एकमुश्त क्षतिपूर्ति राशि दिलाई जाना उचित है।

24. प्रार्थी ने विपक्षी के यहां एक वर्ष नौ माह के लगभग कार्य किया है। अतः उसे एकमुश्त क्षतिपूर्ति राशि 40,000 रु. दिलाये जाना उचित है। उसे इस मुकदमे में खर्च हुई राशि 10,000 रु. भी दिलाये जाना उचित है। अतः प्रार्थी, विपक्षी सं० एक से कुल राशि 50,000 रु. प्राप्त करने का अधिकारी है।

#### ::आदेश::

प्रार्थी श्री दिनेश कुमार शर्मा पुत्र श्री भैरूलाल शर्मा व विपक्षी सं. एक ए.ए.सी. माईनिंग के मध्य श्रमिक-नियोजक के संबंध रहे हैं तथा उसका नियोजन विपक्षी सं. एक के यहां 'नियमित नियोजन' रहा है। उसे अवैध तौर पर सेवा पृथक किया गया, अतः वह अवैध सेवा पृथककरण के एवज में एकमुश्त क्षतिपूर्ति राशि 40,000 रु. व मुकदमे के खर्च के रूप में 10,000 रु. कुल 50,000 (पचास हजार) रु. प्राप्त करने का अधिकारी है। प्रार्थी को पंचाट प्रकाशित होने की तिथि से दो माह में उक्त राशि की अदायगी की जाये, अन्यथा उक्त राशि पर 6 प्रतिशत वार्षिक की दर से ब्याज भी देय होगा।

विपक्षी सं. दो हिन्दुस्तान जिक लि. के विरुद्ध यह प्रकरण खारिज किया जाता है।

पंचाट की प्रति केन्द्र सरकार को प्रकाशनार्थ भेजी जाये।

अजीत कुमार हिंजर, न्यायाधीश

नई दिल्ली, 13 अगस्त, 2020

**का.आ. 703.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार आन्ध्रा बैंक के प्रबंधन के संबंध में नियोजकों और उनके कर्मचारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण/श्रम न्यायालय, चैन्नई के पंचाट (संदर्भ सं. 7/2017) को प्रकाशित करती है जो केन्द्रीय सरकार को 13.08.2020 को प्राप्त हुआ था।

[सं. एल-39025/01/2020-आईआर (बी-II)]

सीमा बंसल, अनुभाग अधिकारी

New Delhi, the 13th August, 2020

**S. O. 703.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 7/2017) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Chennai as shown in the Annexure, in the industrial dispute between the management of Andhra Bank, and their workmen, received by the Central Government on 13.08.2020.

[No. L-39025/01/2020-IR(B-II)]

SEEMA BANSAL, Section Officer

**ANNEXURE**  
**BEFORE THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT**  
**CHENNAI**

**ID No. 7/2017**

**Present:** DIPTI MOHAPATRA, LL.M., PRESIDING OFFICER

Date: 24.06.2020

Sri R. Dilli  
 S/o Ramachandran

...1<sup>st</sup> Party/Petitioner

**AND**

1. M/s. Andhra Bank  
 Regional Office  
 Rep. by its Senior Manager  
 No. 168, Lingi Chetty Street  
 Chennai-600001

...2<sup>nd</sup> Party/1<sup>st</sup> Management

2. M/s. Andhra Bank  
 Rep. by its Branch Manager  
 Senthil Nagar Branch  
 No. 15A, Rajaji Salai, Senthilnagar  
 Tirumullaivoyal  
 Chennai-600062

...2<sup>nd</sup> Party/2<sup>nd</sup> Management

**Appearance:**

For the 1<sup>st</sup> Party/Petitioner : M/s. N. Ganesh, K. Manavalan

For the 2<sup>nd</sup> Party/1<sup>st</sup> & 2<sup>nd</sup> Respondent : M/s. Aiyar & Dolia

**AWARD**

This is an Application under 2A(2) of the Industrial Disputes Act, 1947.

The case of the Applicant in a nutshell is that being appointed as Contractual Gold Appraiser by the First Respondent vide its letter No. LR. 680/16/GJA/382 dtd. 27.01.2007 joined the Second Respondent, the Branch Manager, Senthil Nagar Branch and rendered unblemished service for 9 years. He was terminated from his job without any prior notice, by the Second Respondent on dated 06.10.2015 being victimized due to his complaint before the Authority, regarding illegal demand of Rs. 3.00 lakhs by the then Branch Manager viz. K. Karunanidhi. The issuance of termination letter on dtd. 06.10.2015, is perverse and not in accordance to the principles of natural justice. The Applicant seeks for consequential reliefs as deems fit by setting aside the termination order.

3. Both the Respondents entered appearance by filing a Common Written Statement. The appointment of petitioner as Contractual Jewel Appraiser while was admitted the Respondents strongly denied the claim of the petitioner as he joined as per the terms and conditions of an agreement executed in between him and the Respondents. The Counter Statement filed by the Respondents, denying the allegation of victimization of the petitioner and contended justifying the order of termination of the petitioner as an outcome of sheer violation of the terms and condition of the agreement as agreed upon by the petitioner. The allegation of demand of Rs. 3.00 lakhs by the then Branch Manager for any obvious purpose was turned down as false and baseless.

4. The following issues emerged in the pleadings of the parties.

- (i) If the petitioner is a "Workman" within the purview of the definition of the Act?
- (ii) If his termination without any prior notice is legal and perverse?
- (iii) If so, to what relief he is entitled to?

5. Both the parties adduced oral as well as documentary evidence. The petitioner himself examined as WW1 and produced and marked 13 number of documents from Ext.W1 to Ext.W13. The Respondents preferred to adduce evidence through one of their witness, the Branch Manager, Avadi Branch, Chennai. Only two documents are relied on under Ext.M1 and Ext.M2. In order to avoid confusion it needs mention that both

parties relied on the same document i.e. agreement marked as Ext.W4 on behalf of the petitioner and Ext.M1 on behalf of the Respondent. Thus, it would be hereinafter be referred as “Ext.M1” and not Ext.W4.

6. Since both the issues are interlinked inter-alia, so far the fact and law are concerned, taken up together for a convenient discussion. The Admitted undisputed fact remains on being appointed by the First Respondent and vide its letter No. LR.680/16/GJA/382 dtd. 27.01.2007, the petitioner entered into an Agreement vide no. 21490 dtd. 29.11.2006 (Ext.M1) and joined under the Second Respondent, the Branch Manager, Andhra Bank, Senthil Nagar Branch as Contractual Jewel Appraiser. The Petitioner (WW1) adduced evidence in support of the contentions averred in his 2A Application. The petitioner is stated to have rendered unblemished service for 9 years to the best of his sincerity and satisfaction of the Authority resulting recommendation and engagement for additional charge at Sathyamoorthy Nagar Branch Chennai in the same capacity in the year 2011. He was served with a letter by MW1 for discontinuation of his service as Gold Appraiser vide no. 1277/19/114 dtd. 06.10.2015 (Ext.W5). It was believed by the petitioner that he was victimized, due to his complaint against the then Branch Manager, K. Karunanidhi regarding demand of Rs. 3.00 lakhs for payment of the same to his close acquaintance, one E. Venkatesh. On being pressurized and with a false assurance to get the job secured, the petitioner though could not manage to collect Rs. 3.00 lakhs but could collect only Rs. 2,80,000/- incurring loss of Rs. 2,89,000/- in the account no. 11291029390020 of the petitioner vide two separate cheques. The petitioner was shocked to know that out of the deposited amount, Karunanidhi withdrew Rs. 10,000/- without his knowledge. The Branch Manager turn down the request of petitioner to repay the said amount, on the other hand left for Bengaluru Branch on transfer. The petitioner however lodged complaint before the First Respondent, which was never attended. He once again lodged complaint to the Vigilance Cell of the First Respondent. No action was taken by the Second Respondent on his Complaint. On the other hand he was issued with a letter of discontinuation of service dtd. 06.10.2015 by MW1 basing on the observation made by the Vigilance Department. It is further contended, that the order of discontinuation was the outcome of an unilateral decision of the First Respondent and implemented by the Second Respondent, without affording any opportunity to the Petitioner to represent his case.

7. The Second Respondent, Sri P.S. Nandakumar (the then Branch Manager of Senthil Nagar Branch) has been examined on behalf of the Respondent. In support of the Counter Statement filed by the Respondent he advanced his evidence that the Jewel Appraiser's role is restricted only to check the quality of the jewels of the customers who intend to incur loan from the Bank by pledging the jewels. Besides, when the petitioner joined as per the terms and conditions of the Agreement, he cannot claim his service to be a regular one. That apart, the Employer has every authority to terminate the job, if any deviation is noticed.

In view of the discussion held in preceding paragraphs it is to be seen if the petitioner is a workman within the purview of the Act and his discontinuation from service is not legal and justified. The Learned Counsel on behalf of the Respondent drew attention on the relevant documents i.e. the Approval of Appointment Letter (Ext.W3), the Agreement between the parties (Ext.M1). It is contended that admittedly the appointment of the petitioner was made by the First Respondent on contractual basis. It is also an admitted fact that the petitioner joined as per the terms and conditions of Ext.M1. As such, it is further urged that the petitioner, Contractual Appraiser is not a **workman** within the purview of Section (2) of the Industrial Disputes Act, 1947. Reliance is placed in the judicial verdict of the Supreme Court in the case of *Indian Overseas Bank Vs. All India Indian Overseas Bank Employees Union 2006-2-LLJ-253 (SC)*

8. In view of the evidence adduced by MW1 it reveals the Jewel Appraisers were restricted to appraisal of jewels. Accordingly, he is required to furnish certificate in individual cases. The commission for professional service of Jewel Appraisers are borne by the customers and not by the Bank. It is further stated that the Jewel Appraisers are at liberty to carry on private business outside the premises. Since the Appraisers are required to appraise the jewel as and when required looking into the customers' demand, they are not supposed to remain in the Bank for the whole working hours. The Witness being the Branch Manager while stated about the procedural aspect of the job of the concerned Jewel Appraisers, denied the relief sought for by the petitioner. While emphasizes about the contract executed in between the parties the Witness also justifies the letter (Ext.W5) issued by him. At the outset the Learned Counsel also focussed on the other relevant documents. It is stated the Head Office issued necessary instruction vide Ext.M2 (the letter from Vigilance Department to Zonal Office) to discontinue the service of the petitioner as some serious irregularities in appraisal of gold / jewellery was detected by the Internal Vigilance Department for the relevant period when the petitioner and his Wife, D. Revathy (Petitioner in ID 8/2007) were appointed as Contractual Jewel Appraiser in the Senthil Nagar and Sathyamoorthy Nagar Branch. On further perusal of the Ext.M2, it reveals that in a routine manner the Internal Vigilance Department of the First Respondent re-appraised 20% of gold jewels in random of the above two Branches for the relevant period when the Petitioner and his Wife were appointed. The Appraisers are required to give the report of the net weight of gold and the certificate regarding the quality of the gold. Accordingly, the Gold Appraisers are under obligation to deduct the weight of stones, beads and plastics, if any found in the

jewellery placed for appraisal by the customers. After the deduction of such weight, the Appraiser is to place the report of net weight. On such report of net weight and assessed quality of gold necessary loan is sanctioned by the Bank in favour of the borrower. As such the report of the Jewel Appraiser plays a vital role in assisting the Bank in such field. Ext.M2 discloses in the instant random re-appraisal of 20% of gold ornaments of both the Branches viz. Senthil Nagar and Sathyamoorthy Nagar Branch, the Internal Vigilance Department noticed severe discrepancies as the appraisal of gold jewellery was not held properly. Both the petitioner and his wife, D. Revathy were appointed as Contractual Gold Jewel Appraisers for the respective branches for the relevant period and found negligent in discharging their bonafide duties. While appraising the net weight of gold, both of them were found to have failed to deduct the weight of stones, beads and plastics from the concerned jewellery but shown the net weight as such. Accordingly, it is contended that the petitioner deviated from the terms and conditions of the contract causing monetary loss to the Bank. Ext.M1 in this regard is taken into account. Admittedly, Ext.M1 in a clear and unequivocal terms speaks that the Appraiser shall faithfully and diligently do or perform the work or the duties assigned by the Respondent's Bank. It was also observed by the Internal Vigilance Department that for the obvious cause of personal gain the Petitioner and his Wife promoted illegitimate monetary relation with the staff members of the Branch so also wilfully frustrated the terms and conditions of the Agreement. The report was submitted before the First Respondent for taking appropriate action at their end. The First Respondent directed the Second Respondent to terminate the Petitioner and his Wife from job. Pursuant to the letter of the Head Office, the Second Respondent implemented the instruction by issuing the letter of discontinuation (Ext.W3). The allegations against the then Branch Manager by the petitioner was an afterthought and without any basis.

9. In view of the submission of Learned Counsels of both parties and the discussion held in preceding paragraphs it reveals that the appointment of the Petitioner was in accordance to the terms and conditions of Agreement (Ext.M1). When the Petitioner is one of the party to the Agreement it is well presumed that he has been well aware of the terms and conditions contemplated in the Agreement. One of such condition says that the Appraiser shall be liable if any mistake, omission, neglect or misconduct made or committed by him in the performance of his duties. As such when Internal Vigilance Department observed there was serious negligence attributed by the Jewel Appraisers causing loss to the Bank, the then Assistant Manager, Vigilance moved the Competent Authority, the Senior Manager, Zonal Office vide his letter (enclosed with the details of the random checklist) to the Zonal Office, Chennai. The Competent Authority, the First Respondent looking into the gravity and seriousness advised the Second Respondent to discontinue the service of the Gold Appraiser i.e. the Petitioner and his Wife, D. Revathy (Petitioner in ID 8/2007). The Learned Counsel for the Respondent while justifies the letter under Ext.M2 (letter from Vigilance to Zonal Office) and Ext.W5 (letter of termination) draws attention to the very relevant Clause-18 of the Agreement of Ext.M1.

The Clause 18 of Ext.M1 reads as follows -

***“that any loss or damage if caused to the Bank due to the negligence, carelessness of the Appraiser or his Authorized Deputy during the performance of his responsibilities or if the Appraiser or his Authorized Deputy has committed fraud or practised dishonesty or has committed gross misconduct or breach of terms and conditions of this Agreement, it shall be lawful for the Bank to put an end to the Agreement forthwith by giving the Appraiser and the Guarantor written notice of its intention forthwith and whether or not the circumstances in any particular case justify the Bank in summarily putting to an end to this Agreement shall be decided solemnly by the Bank”.***

10. Accordingly, in view of the discussion held in preceding paragraphs it is apparent from the letter Ext.M2 that the Competent Authority, the First Respondent, the Senior Manager of Zonal Office was fully convinced with the report and observation of the Internal Vigilance Department that there was serious deviation to the terms and condition of the Agreement, wilful negligence on the part of the then Jewel Appraiser in appraisal of jewellery and arriving at incorrect net weight causing severe loss to the Bank. It is held by the Authority that the service of the respective Jewel Appraisers were no more required in the given fact and circumstance and directed the Second Respondent to terminate the petitioner from service. It is highlighted by the Learned Counsel for the Respondent so also from the materials borne out of documents on record that the Petitioner has never challenged the direction of the First Respondent in any competent Forum. Thus, the direction of the First Respondent holds good till issuance of letter of termination by the Second Respondent. Besides, it further appears in view of the terms and conditions of Clause-18, the First Respondent was competent enough to decide summarily and solemnly to put to an end to the agreement (Ext.M1). Thus in this scenario it is crystal clear that the Second Respondent had no role to play in the decision taken by the First Respondent. On the other hand, the Second Respondent being the Subordinate Officer was left with no option other than to comply with the direction of the higher Authority, the First Respondent. The Second Respondent



simply complied the order of the higher authority, the First Respondent, the Senior Manager, Zonal Office. The Second Respondent implemented the direction by issuing Ext.M2.

In view of the discussion held supra, the decision taken by the First Respondent to terminate the Petitioner from job cannot said to be improper and illegal so also the issuance of letter of termination of the petitioner from job by the Second Respondent is held legal and justified and warrants no interference. In the result, the Petitioner, R. Dilli is not entitled to any relief as sought for.

In the result the reference is answered against the petitioner. The Industrial Dispute stands dismissed.

An Award is passed accordingly.

DIPTI MOHAPATRA, Presiding Officer

**Witnesses Examined :**

For the 1 <sup>st</sup> Party/Petitioner	:	WW1, Sh. R.Dilli
For the 2 <sup>nd</sup> Party/Respondent	:	MW1, Sri P.S. Nandakumar

**Documents Marked:-**

**On the petitioners side**

Ex. No.	Date	Description
Ex.W1	-	Identity Card Issued by Gold Silver Appraiser Society
Ex.W2	23.04.2004	Certificate Issued by SISI (GOI)
Ex.W3	27.01.2007	Approval of Appointment letter
Ex.W4	-	Agreement between petitioner and Respondent
Ex.W5	06.10.2015	Discontinuation of service letter
Ex.W6	07.04.2016	Tamilnadu State Legal Service Authority Call Letter
Ex.W7	17.06.2016	Statement of Objection filed by the R2
Ex.W8	30.08.2016	District Legal Service Authority Letter to High Court Legal Service Committee
Ex.W9	06.09.2016	High Court Legal Service to Advocate Mr. T. Saravanan
Ex.W10	21.09.2016	Legal Opinion of Advocate Mr. T.Saravanan
Ex.W11	17.10.2016	Petition to Dy. CLC (C).
Ex.W12	12.12.2016	Respondent Comments to Dy. CLC (C).
Ex.W13	31.01.2017	Certificate issued by Dy. CLC (C) (No Settlement Reached ).

**On the Respondent side**

Ex.No.	Date	Description
Ex.M1	29.11.2006	Appraiser Agreement of Mr. R. Dilli
Ex.M2	19.09.2015	Letter from Vigilance Department to Zonal Office

नई दिल्ली, 13 अगस्त, 2020

**का.आ. 704.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में केन्द्रीय सरकार आन्ध्रा बैंक के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण/श्रम न्यायालय, चैन्नई के पंचाट (संदर्भ सं. 8/2017) को प्रकाशित करती है जो केन्द्रीय सरकार को 13.08.2020 को प्राप्त हुआ था।

[सं. एल-39025/01/2020-आईआर (बी- II)]

सीमा बंसल, अनुभाग अधिकारी

New Delhi, the 13th August, 2020

**S. O. 704.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 8/2017) of the Cent. Govt. Indus.Tribunal-cum-Labour Court, Chennai as shown in the Annexure, in the industrial dispute between the management of Andhra Bank, and their workmen, received by the Central Government on 13.08.2020.

[No. L-39025/01/2020-IR(B-II)]

SEEMA BANSAL, Section Officer

**ANNEXURE****BEFORE THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT  
CHENNAI****ID No. 8/2017****Present:** DIPTI MOHAPATRA, LL.M., PRESIDING OFFICER

Date: 24.06.2020

Sri D. Revathy  
W/o Sri R. Dilli... 1<sup>st</sup> Party/Petitioner**AND**

1. M/s. Andhra Bank  
Zonal Office  
Rep. by its Senior Manager  
No. 168, Lingi Chetty Street  
Chennai-600001

... 2<sup>nd</sup> Party/1<sup>st</sup> Management

2. M/s. Andhra Bank  
Rep. by its Branch Manager  
Sathyamoorthy Nagar Branch  
No. 1, Solambedu Road  
Tirumullaivoyal  
Chennai-600062

... 2<sup>nd</sup> Party/2<sup>nd</sup> Management**Appearance:**For the 1<sup>st</sup> Party/Petitioner : M/s. N. Ganesh, K. ManavalanFor the 2<sup>nd</sup> Party/1<sup>st</sup> & 2<sup>nd</sup> Respondent : M/s. Aiyar & Dolia**AWARD**

This is an Application under 2A(2) of the Industrial Dispute Act, 1947.

2. The case of the Applicant in a nutshell is that being appointed as Contractual Gold Appraiser by the First Respondent vide its letter no. LR.0680/19/GI55/129 dtd. 09.01.2013 joined the Second Respondent, the Branch Manager, Sathyamoorthy Nagar Branch and rendered unblemished service throughout the tenure. She was terminated from her job without any prior notice by the Second Respondent on dated 06.10.2015. It is understood that basing on the observation made by the Vigilance Department she was victimized and terminated from service. The issuance of termination letter on dtd. 06.10.2015 is accordingly challenged as illegal. The Petitioner sought for her reinstatement and at the same time demanded compensation of Rs. 10,000/- per month with Rs. 10,000/- as litigation expenses from the Respondent.



3. Both the Respondents entered appearance by filing a Common Written Statement. The appointment of petitioner as Contractual Jewel Appraiser while was admitted, the Respondents strongly denied the claim of the petitioner. It is added that since the Petitioner joined pursuant to the agreement executed in between her and the Respondent is not under payroll of the Respondents. Therefore is not liable for the reliefs as sought for. The Respondents accordingly denied the allegation of victimization of the petitioner but made the submission justifying the order of termination of the petitioner as an outcome of sheer violation of the terms and condition of the Agreement as agreed upon by the petitioner.

4. The following issues emerged in the pleadings of the parties.

- (i) If the petitioner is a “Workman” within the purview of the definition of the Act?
- (ii) If her termination without any prior notice is legal and perverse?
- (iii) If so, to what relief she is entitled to?

5. Both the parties adduced oral as well as documentary evidence. The petitioner herself examined as WW1 and produced a bunch of documents from Ext.W1 to Ext.W11 which includes the I-Card, Appointment Letter and also the Termination Letter. All other documents from Ext.W5 to Ext.W11 relates to the matter before the Tamil Nadu S.L.S.A. and DLC.

6. The Branch Manager, Sri P.S. Nanda Kumar, Avadi Branch, Chennai was examined as MW1 and produced two documents viz. the Agreement dtd. 05.01.2014 and the letter from Vigilance Department of Zonal Office dtd. 19.09.2015 marked as Ext.M1 and Ext.M2 respectively.

#### Issue (i) & (ii)

7. Since both the issues are interlinked inter-alia, so far the fact and law are concerned, taken up together for a convenient discussion. The Admitted undisputed fact remains that on being appointed by the First Respondent and vide its letter No. LR.0680/19/GI55/129 dtd. 09.01.2013, the petitioner entered into an Agreement vide Ext.M1 and joined as Contractual Jewel Appraiser under the Second Respondent, the Branch Manager, Andhra Bank, Sathyamoorthy Nagar Branch. The Petitioner (WW1) adduced evidence in support of the contentions averred in her 2A application. The petitioner is stated to have rendered unblemished service throughout her tenure to the best of her ability and to the satisfaction of the Authority. But to her utter surprise, she was served with a letter by the Second Respondent for discontinuation of her service as Gold Appraiser vide letter dtd. 06.10.2015 (Ext.W4). She was never been afforded with any opportunity to represent her case but without any prior notice, was terminated from her job. It was believed by the petitioner that she was victimized and terminated simply pursuant to the observation of the Vigilance Department. She approached different forums such as the State Legal services Authorities and the Dy. Labour Commissioner for redressal of her grievance but in vain. She moved the Tribunal in the instant case seeking her reinstatement and other consequential reliefs.

8. Sri P.S. Nandakumar, the Second Respondent, the then Branch Manager (MW1) was examined on behalf of the Respondent. In support of the Counter Statement filed by the Respondent he advanced his evidence that the Jewel Appraiser's role is restricted only to check the quality of the jewels of the customers who intend to incur loan from the Bank by pledging the jewels. Besides, when the petitioner joined as per the terms and conditions of the Agreement, she cannot claim her service to be a regular one. That apart, the Employer has every authority to terminate the job, if any deviation to the terms and conditions of the Agreement is noticed.

9. In view of the discussion held in preceding paragraphs it is to be seen, if the petitioner is a workman within the purview of the Act and her discontinuation from service is not legal and justified? The Learned Counsel on behalf of the Respondent drew attention on the relevant documents i.e. the Approval of Appointment Letter (Ext.W3), the Agreement between the parties (Ext.M1). It is contended that admittedly the appointment of the petitioner was made by the First Respondent on contractual basis. It is also an admitted fact that the petitioner joined as per the terms and conditions of Ext.M1. As such, it is further urged that the petitioner, Contractual Appraiser is not a **workman** within the purview of Section (2) of the Industrial Disputes Act, 1947. Reliance is placed in the judicial verdict of the Supreme Court in the case of *Indian Overseas Bank Vs. All India Indian Overseas Bank Employees Union 2006-2-LLJ-253 (SC)*

10. In view of the evidence adduced by MW1 it reveals the Jewel Appraisers were restricted to appraisal of jewels. Accordingly, they are required to furnish certificate in individual cases. The commission for professional service of Jewel Appraisers are borne by the customers and not by the Bank. It is further stated that the Jewel Appraisers are at liberty to carry on private business outside the premises. Since the Appraisers are required to appraise the jewel as and when required looking into the customers' demand, they are not supposed to remain in the Bank for the whole day (working hours). The Witness being the Branch Manager while stated about the

procedural aspect of the job of the concerned Jewel Appraisers, denied the relief sought for by the petitioner. While emphasizes about the contract executed in between the parties the witness also justifies the letter (Ext.W4) issued by him. At the outset the Learned Counsel also focussed on the other relevant documents. It is stated the Head Office issued necessary instruction vide Ext.M2 (the letter from Vigilance Department to Zonal Office) to discontinue the service of the petitioner as some serious irregularities in appraisal of gold / jewellery was detected by the Internal Vigilance Department for the relevant period when the Petitioner's husband R. Dilli (Petitioner in ID 7/2007) was appointed as Contractual Jewel Appraiser in the Senthil Nagar was also appointed for some time to other Branches including Sathyamoorthy Nagar Branch, where the petitioner was appointed. On further perusal of the Ext.M2, it further reveals that in a routine manner the Internal Vigilance Department of the First Respondent, re-appraised 20% of gold jewels in random of the above two Branches of the relevant period when the Petitioner and her Husband were appointed. The Appraisers are required to give the report of the net weight of gold and the certificate regarding the quality of the gold. Accordingly, the Gold Appraisers are under obligation to deduct the weight of stones, beads and plastics, if any found in the jewellery placed for appraisal by the customers. After the deduction of such weight, the Appraiser is to place the report of net weight. On such report of net weight and assessed quality of gold, necessary loan is sanctioned by the Bank in favour of the Borrower. As such the report of the Jewel Appraiser plays a vital role in assisting the Bank in such field. Ext.M2 discloses that in the instant random re-appraisal of 20% of gold ornaments of both the Branches viz. Senthil Nagar and Sathyamoorthy Nagar Branch, the Vigilance Department noticed severe discrepancies. The appraisal of gold jewellery was not held properly by the respective Jewel appraisers. Both the petitioner and her Husband R. Dilli were appointed as Contractual Gold Jewel Appraisers for the respective branches for the relevant period and found negligent in discharging their bonafide duties. While appraising the net weight of gold, both of them were found to have failed to deduct the weight of stones, beads and plastics from the concerned jewellery but shown the net weight as such. Accordingly, it is contended that the petitioner deviated from the terms and conditions of the contract causing monetary loss to the Bank. Ext.M1 in this regard is taken into account. Admittedly, Ext.M1 (The Agreement) in a clear and unequivocal terms speaks that the Appraiser shall faithfully and diligently do or perform the work or the duties assigned by the Respondent's Bank. It was also observed by the Internal Vigilance Department that for the obvious cause of personal gain, the petitioner and her Husband promoted illegitimate monetary relation with the staff members of the Branch so also wilfully frustrated the terms and conditions of the agreement. The report was submitted before the First Respondent for taking appropriate action at their end. The First Respondent directed the Second Respondent to terminate the Petitioner and her Husband from job. Pursuant to the letter of the Head Office, the Second Respondent implemented the instruction by issuing the letter of discontinuation (Ext.W3). It is further contended that the allegations against the then Branch Manager by the Petitioner was an afterthought and without any basis.

11. In view of the submission of Learned Counsel for both parties and the discussion held in preceding paragraphs, it reveals that the appointment of the Petitioner was in accordance to the terms and conditions of Agreement (Ext.M1). When the Petitioner is one of the party to the Agreement it is well presumed that she has been well aware of the terms and conditions contemplated in the Agreement. One of such condition says that the Appraiser shall be liable if any mistake, omission, neglect or misconduct made or committed by her in the performance of her duties. As such when Internal Vigilance Department observed that there was serious negligence attributed by the Jewel Appraisers causing loss to the Bank, the then Assistant General Manager, Vigilance moved the Competent Authority, the Senior Manager, Zonal Office vide his letter (enclosed with the details of the random checklist) to the Zonal Office, Chennai. The Competent Authority, the First Respondent looking into the gravity and seriousness, advised to the Second Respondent to discontinue the service of Gold Appraisers i.e. the Petitioner, R. Revathy and her Husband, R. Dilli (Petitioner in ID 7/2007). The Learned Counsel for the Respondent while justifies the letter under Ext.M2 (letter from Vigilance Zonal Office) and Ext.W4 (letter of termination) draws attention to the very relevant Clause (18) of the Agreement (Ext.M1).

The Clause 18 of Ext.M1 reads as follows -

*“that any loss or damage if caused to the Bank due to the negligence, carelessness of the Appraiser or his Authorized Deputy during the performance of his responsibilities or if the Appraiser or his Authorized Deputy has committed fraud or practised dishonesty or has committed gross misconduct or breach of terms and conditions of this Agreement, it shall be lawful for the Bank to put an end to the Agreement forthwith by giving the Appraiser and the Guarantor written notice of its intention forthwith and whether or not the circumstances in any particular case justify the Bank in summarily putting to an end to this Agreement shall be decided solemnly by the Bank”.*

12. Accordingly, in view of the discussion held in preceding paragraphs it is apparent from the letter Ext.M2 that the Competent Authority, the First Respondent, the Senior Manager of Zonal office, was fully convinced with the report and observation of the Internal Vigilance Department, that there was serious deviation

to the terms and conditions of the Agreement, wilful negligence on the part of the then Jewel Appraiser in appraisal of jewellery and arriving at incorrect net weight causing severe loss to the Bank. It is held by the Authority that the service of the respective Jewel Appraisers were no more required in the given facts and circumstance and directed the Second Respondent to terminate the Petitioner from the service. It is also highlighted by the Learned Counsel for the Respondent so also reveal from the materials borne out of documents on record that the Petitioner has never challenged the direction of the First Respondent in any competent Forum. Thus, the direction of the First Respondent holds good, till the issuance of letter of termination by the Second Respondent. Besides, it further appears in view of the terms and conditions of Clause-18 of Ext.M1, the First Respondent, the Senior Manager, Zonal Office was competent enough to decide summarily and solemnly to put to an end to the agreement (Ext.M1). Thus, in this scenario it is crystal clear that the Second Respondent had no role to play in the decision taken by the First Respondent. On the other hand, the Second Respondent being the Subordinate Officer was left with no option other than to comply with the direction of the higher Authority, First Respondent. The Second Respondent simply complied the order of the higher Authority, First Respondent, the Senior Manager, Zonal Office. The Second Respondent implemented direction.

13. In view of the discussions held supra, the decision taken by the First Respondent to terminate the petitioner from job cannot said to be improper and illegal so also the issuance of letter of termination of Petitioner from her job, by the Second Respondent is held legal and justified, warrants no interference. In the result, the Petitioner, D. Revathi is not entitled to any relief as sought for.

The reference is answered against the petitioner. The Industrial Dispute case stands dismissed.

An Award is passed accordingly.

DIPTI MOHAPATRA, Presiding Officer

(Dictated and transcribed by PA and  
corrected and pronounced in the open  
court on this day the 24.06.2020)

**Witnesses Examined :**

For the 1<sup>st</sup> Party/Petitioner : WW1, Smt.D.Revathy  
For the 2<sup>nd</sup> Party/1<sup>st</sup> & 2<sup>nd</sup> Respondent : MW1, Sh. P.S.Nandakumar

**Documents Marked:-**

**On the petitioners side**

Ex.No.	Date	Description
Ex.W1	-	Identity Card Issued by Gold Silver Appraiser Society
Ex.W2	29.08.2013	Certificate Issued by BSS Skill School
Ex.W3	27.01.2007	Appointment letter of the Petitioner
Ex.W4	06.10.2015	Termination of service of the Petitioner
Ex.W5	15.07.2016	Tamilnadu State Legal Service Authority Call Letter
Ex.W6	30.08.2016	District Legal Service Authority Letter Chennai
Ex.W7	06.09.2016	High Court Legal Service to Advocate Mr.T.Saravanan
Ex.W8	21.09.2016	Legal Opinion of Advocate Mr. T.Saravanan
Ex.W9	17.10.2016	Petition to Dy. CLC (C).
Ex.W10	12.12.2016	2 <sup>nd</sup> Respondent's reply to Petitioner's Complaint before Dy. CLC (C).
Ex.W11	31.01.2017	Certificate issued by Dy. CLC (C) (No Settlement Reached ).

**On the Respondent side**

Ex.No.	Date	Description
Ex.M1	05.01.2014	Appraiser Agreement of Mrs. D. Revathy
Ex.M2	19.09.2015	Letter from Vigilance Department to Zonal Office

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 705.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 5/2016) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/93/2015-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 705.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 5/2016) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/93/2015-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 13<sup>th</sup> day of March, 2020**INDUSTRIAL DISPUTE No. 5/2016****Between:**

The President (Bandari Satyanarayana)  
Rashtriya Colliery Mazdoor Sangh (INTUC),  
Rajkumar Complex, Saibaba Temple Road,  
Jaffar Nagar, Mancherla-504209.

...Petitioner

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Mandamarri Area, Mandamarri (P.O.)  
Adilabad district -504 231.

...Respondent

**Appearances:**

For the Petitioner : Sri Sangars Bhagawanth Rao, Advocate

For the Respondent : M/s. P.A.V.V.S. Sarma &amp; Vijaya Laxmi P., Advocates

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L-22012/93/ 2015 -IR(CM-II) dated 23.12.2015 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Mandamarri, Adilabad Distt. in terminating the services of Sri Lingala Venkateshwarlu, Ex-Coal Filler, Kasipeta Mine, SCCL, Mandamarri Area, with effect from 28.10.2004 is justified or not? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 5/2016 and issued notices to both the parties and secured their presence.



**2. The Petitioner Union filed claim statement with the averments in brief as follows:**

It is submitted in the representation of the Petitioner Union that, the workman Sri Lingala Venkateshwarlu was initially appointed as a Badli Coal Filler on 9.6.1988. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, during the year 2002, the workman suffered ill-health as a result of which, he could not be regular to his duties during the year 2002. While the matters stood thus, he was issued with a charge sheet alleging that the workman remained absent during the year 2002, which amounts to misconduct under company's Standing Order No. 25.25. Subsequently, one enquiry was conducted and the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service vide office order dated 25.4.2004. It is stated that the Workman has categorically stated about his inability to perform his duties regularly during the year 2002, which was only on account of his ill-health and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 16 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the Respondent management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

**3. Respondent filed counter with the averments in brief as follows:**

In the counter the Respondent while admitting some of the factual aspects to be true, stated that the Workman was appointed in the Respondent's organization on 9.8.1988 as a Badli Filler and later promoted as a Coal Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman attended the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved for his unauthorized absence in the year 2001 but not for the year 2002 as per the averments made in the claim statement by the Petitioner. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view, and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner conceding the validity of the domestic enquiry conducted by the Respondent, the domestic enquiry conducted by the Respondent is held legal and valid vide order dated 9.9.2019.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

**6. In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Lingala Venkateshwarlu is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No.I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that, during the year 2001/2002, the workman suffered ill-health. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing capital punishment. But, the authority has not considered any of the submissions of the Workman, and has given

capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to the ill-health of the workman and other family problems, the Workman could not be able to regular in his duty, the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 47 years, he is now aged about 52 years and is searching ways and means to provide bread and butter to his family members. When the Workman being an able bodied and energetic man and has already realised his mistake and is coming forward to work under the Respondent, atleast one chance should be given to him for his reinstatement into service at the end of his service period. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Workman is a first offender and has worked for about 16 years under the Respondent, while imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent management for dismissal of service is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Lingala Venkateshwarlu is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Lingala Venkateshwarlu is not legal and justified. After dismissal of service as stated earlier, when the Workman has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Workman has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Workman should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Workman has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Workman is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the Chief General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Adilabad Dist., in terminating the services of Sri Lingala Venkateshwarlu, Ex-Coal Filler, Kasipeta Mine, SCCL, Mandamarri Area, with effect from 28.10.2004 is not justified and is hereby set aside. It is ordered that the workman be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman cannot claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc.. to the workman for his appointment afresh and as such the reference is answered accordingly. So also the, award is passed accordingly. Transmit.



Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 13<sup>th</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

**Appendix of evidence**

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Workman**

NIL

Documents marked for the Respondent

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 706.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-मह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 36/2016) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/32/2016-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 706.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 36/2016) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/32/2016-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE**

**IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD**

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 13<sup>th</sup> day of March, 2020

**INDUSTRIAL DISPUTE No. 36/2016**

**Between:**

Sri Pasham Nageswara Rao,  
H.No. 22-2-103, Subhashnagar,  
Basthi, Bellampalli  
Adilabad Distt.  
Adilabad – 504251.

...Petitioner

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Bhupalapalli Area, Bhupalapalli(P.O.)  
Warangal district – 506 169

...Respondent

**Appearances:**

For the Petitioner : M/s. A. Sarojana, K. Vasudeva Reddy & B. Kiran Kumar, Advocates

For the Respondent : M/s. P.A.V.V.S. Sarma, P. Vijaya Laxmi & Dasaradha Ramulu, Advocates

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L- 22012/32/2016-IR(CM-II) dated 15.7.2016 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamari Area, Warangal Distt., in terminating the services of Sri Pasham Nageswara Rao, Coal Filler, KTK-5 Inc., SCCL, Bhupalapalli Area with effect from 1.9.2006 is justified or not? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 36/2016 and issued notices to both the parties and secured their presence.

**2. The Petitioner filed claim statement with the averments in brief as follows:**

The workman Sri Pasham Nageswara Rao was initially appointed on 3.1.1986 as a Badli Filler and later he was promoted as Coal Filler. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, he could not be regular to his duties during the year 2003, due to death of his mother in the year 2003, demise of his father in the year 2004 and his brother in the year 2005, and his ill-health as he suffered from nerves problems and speech problem. While the matters stood thus, a charge sheet dated 12.7.2004 was issued to him by the Respondent alleging that the Workman absented for duty during the year 2003, which amounts to misconduct under company's Standing Order No.25.25. The workman could not submit his explanation to the charge sheet nor participated in the enquiry, wherein the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service through proceeding dated 28/30.8.2006 with effect from 1.9.2006. It is stated that during the course of the enquiry the Workman has categorically stated about his inability to perform his duties regularly during the year 2003, which was only on account of the death of his parents and his brother, his ill-health and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 20 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

**3. Respondent filed counter with the averments in brief as follows:**

In the counter the Respondent while admitting some of the factual aspects to be true, stated that the Workman was appointed in the Respondent's company as a Badli Filler on 10.2.1986. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman did not participate in the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view and lastly, the Respondent was constrained to

dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner stating therein that the Petitioner is not interested to prosecute the issue of validity of domestic enquiry conducted by the Respondent, therefore the validity of domestic enquiry is held as legal and valid vide order dated 3.1.2019.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

6. **In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Pasham Nageswara Rao is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that due to death of his parents, his brother, his ill-health and other family problems, the Workman could not be able to attend his duty sincerely. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing capital punishment. The authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to the death of his mother in the year 2003, demise of his father in the year 2004 and his brother in the year 2005, and Petitioner's ill-health who suffered from nerves problems and speech problem, he [the Workman] could not be able to be regular in his duty, ultimately the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 55 years, he is now aged about 59 years and has already attained the age of superannuation, and at this age he is searching ways and means to provide bread and butter to his family members. In such a circumstances, atleast one chance should be given to him for his reinstatement into service in order to get all his terminal benefits. Admittedly several modes of punishment are enumerated in company's Standing Orders. But the management decided to impose capital punishment. The Petitioner is a first offender and has worked for about twenty years under the Respondent. While imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondents for dismissal of service is too harsh and is not proper. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Pasham Nageswara Rao is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Pasham Nageswara Rao is not legal and justified. After dismissal of service as stated earlier, when the Petitioner has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Petitioner has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances, the Petitioner should be given a chance to maintain his livelihood and to work under the Respondents' management. But unfortunately, during the pendency of this case the Petitioner has attained the age of superannuation. So, question of rendering any service to the Respondents is

not expected from the Petitioner. But only he is to be reinstated into service to get all his service benefit and also entitled to get 30% of back wages.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamarii Area, Adilabad Distt., in terminating the services of Sri Pasham Nageswara Rao, Coal Filler, KTK-5 Inc., SCCL, Bhupalapalli Area with effect from 1.9.2006 is not justified. Proceeding No. BHP/PER/20-D/3356 dated 28/30.8.2006 issued by the Respondent is declared as illegal and the same is hereby set aside. It is ordered that the workman Sri Pasham Nageswara Rao be reinstated in service only to get all his terminal benefits. He is entitled to get 30% of back wages. The Respondents are directed to give all the terminal benefits along with 30% of back wages to the Petitioner after four months of receipt of this order, failing which the Petitioner is at liberty to recover the same through the process of law.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 13<sup>th</sup> day of March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### **Appendix of evidence**

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

### **Documents marked for the Workman**

NIL

### **Documents marked for the Respondent**

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 707.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 66/2015) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/49/2015-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 707.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 66/2015) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/49/2015-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 24<sup>th</sup> day of February, 2020**INDUSTRIAL DISPUTE No. 66/2015****Between:**Sri Bogiri Mallian,  
H.No. 2-4/1, Manthani (V) & (M)-505184  
Karimnagar Dist.

...Petitioner

**AND**The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Ramagundam-I Area, Godavarikhani-505 209.

...Respondent

**Appearances:**

For the Petitioner : None

For the Respondent : M/s. Nandigam Krishna Rao, N.S. Pattabhi Rama Rao & N. Dasaradha Ramulu,  
Advocates**AWARD**

The Government of India, Ministry of Labour by its order No. L-22012/49/2015-IR(CM-II) dated 29.7.2015 referred the following dispute between the management of M/s. Singareni Collieries Company Ltd., and their workman under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal. The reference is,

**SCHEDULE**

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Ramagundam-I Area, Godavarikhani, Karimnagar Dist., in terminating the services of Sri Bogiri Mallaiah, Ex- CF, GDK-11A Inc., SCCL Ramagundam-I Area, Godavarikhani with effect from 10.9.2001 is justified or not? If not, to what relief the applicant is entitled for?”

The reference is numbered in this Tribunal as I.D. No. 66/2015 and notices were issued to the parties concerned.

2. The case was posted for filing of claim statement by the Petitioner but, notices served on the Petitioner returned unserved. Non appearance of the Petitioner and non taking of any steps to pursue his case clearly indicates that perhaps the Petitioner is not interested to pursue his case. In the circumstances stated above, it is not desirable to linger the case to date to date awaiting the appearance of the Petitioner. Hence, the case of the Petitioner workman is closed and a ‘No dispute’ award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 24<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Presiding Officer

**Appendix of evidence**Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Petitioner**

NIL

**Documents marked for the Respondent**

NIL



नई दिल्ली, 14 अगस्त, 2020

**का.आ. 708.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 37/2016) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/31/2016-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 708.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 37/2016) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/31/2016-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 6<sup>th</sup> day of July, 2020**INDUSTRIAL DISPUTE No. 37/2016****Between:**

Sri Mukkera Mallesh,  
H.No.1-45,Batwanpalli,  
P.O.& Mandal: Bellampalli  
Adilabad Distt.  
Adilabad – 504251

...Petitioner

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Mandamarri Area, Mandamarri (P.O.)  
Adilabad district – 504231.

... Respondent

**Appearances:**

For the Petitioner : M/s. A. Sarojana &amp; K. Vasudeva Reddy, Advocates

For the Respondent : M/s. P. A.V.V.S. Sarma, P. Vijaya Laxmi &amp; Dasaradha Ramulu, Advocates

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L- 22012/31/2016-IR(CM-II) dated 15.7.2016 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Adilabad Distt., in terminating the services of Sri Mukkera Mallesh, Coal Filler, MK-4 Inc., SCCL, Mandamarri Area with effect from 12.2.2008 is justified or not? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 37/2016 and issued notices to both the parties and secured their presence.



**2. The Petitioner filed claim statement with the averments in brief as follows:**

The workman Sri Mukkera Mallesh was initially appointed in the year 1986 as Badli Filler and later he was promoted as Coal Filler. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, he could not be regular to his duties during the year 2005 due to his ill-health, death of his parents in the year 2004 and other family problems. While the matters stood thus, a charge sheet dated 25.2.2006 was issued to him by the Respondent alleging that the Workman absented for duty during the year 2004, which amounts to misconduct under company's Standing Order No.25.25. The workman submitted explanation to the charge sheet and participated in the enquiry, wherein the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service through proceeding dated 6.2.2008 with effect from 12.2.2008. It is stated that during the course of the enquiry the Workman has categorically stated about his inability to perform his duties regularly during the year 2005, which was only on account of death of his parents, his ill-health and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 19 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

**3. Respondent filed counter with the averments in brief as follows:**

In the counter the Respondent while admitting some of the factual aspects to be true, stated that the Workman was appointed in the Respondent's company as a Badli Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman participated in the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner stating therein that the Petitioner is not pressing the issue of validity of domestic enquiry conducted by the Respondent, the validity of domestic enquiry is held as legal and valid vide order dated 3.1.2019.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

**6. In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Mukkera Mallesh is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No.I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that due to death of his parents, his ill-health and other family problems, the Workman could not be able to attend his duty sincerely. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing capital punishment. The authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company to be held is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his illness and other family problems, the Workman could not be able to be regular in his duty, the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and is unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 56 years, he is now aged about 60 years and has already attained the age of superannuation, and at this age he is searching ways and means to provide bread and butter to his family members. In such a circumstances, atleast one chance should be given to him for his reinstatement into service in order to get all his terminal benefits. Admittedly several modes of punishment are enumerated in company's Standing Orders. But the management decided to impose capital punishment. The Petitioner is a first offender and has worked for about twenty two years under the Respondent. While imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondents for dismissal of service is too harsh and is not proper. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Mukkera Mallesh is not legal and justified.

Thus, Point No. I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Mukkera Mallesh is not legal and justified. After dismissal of service as stated earlier, when the Petitioner has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Petitioner has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances, the Petitioner should be given a chance to maintain his livelihood and to work under the Respondents' management. But unfortunately, during the pendency of this case the Petitioner has attained the age of superannuation. So, question of rendering any service to the Respondent is not expected from the Petitioner. But only in this case the Petitioner is to be reinstated into service to get all his service benefit and also entitled to get 30% of back wages.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Adilabad Distt., in terminating the services of Sri Mukkera Mallesh, Coal Filler, MK-4 Inc., SCCL, Mandamarri Area with effect from 12.2.2008 is not justified. Proceeding No. MMR/PER/D/072/08/766 dated 6.2.2008 issued by the Respondent is declared as illegal and the same is hereby set aside. It is ordered that the workman Sri Mukkera Mallesh be reinstated in service only to get all his terminal benefits. He is entitled to get 30% of back wages. The Respondents are directed to give all the terminal benefits along with 30% of back wages to the Petitioner after four months of this order, failing which the Petitioner is at liberty to recover the same through the process of law.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 6<sup>th</sup> day of July, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### **Appendix of evidence**

Witnesses examined for the  
Workman  
NIL

Witnesses examined for the  
Respondent  
NIL

Documents marked for the Workman  
NIL

**Documents marked for the Respondent**  
NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 709.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या एल सी 149/2013) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22013/01/2020-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 709.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. LC 149/2013) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22013/01/2020-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

#### ANNEXURE

#### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 19<sup>th</sup> day of February, 2020

#### INDUSTRIAL DISPUTE L.C.No. 149/2013

#### **Between:**

Sri D. Vijaya Kumar,  
S/o Late D. Veera Reddy,  
R/o Qtr No.1296, Narsapur Colony,  
CCC Post, Mancherla.

...Petitioner

**AND**

The General Manager,  
The Singareni Collieries Company Ltd.,  
Srirampur, Kothagudem (Post)  
Khammam District – A.P.

...Respondent

#### **Appearances:**

For the Petitioner : M/s. V.S. Sudhakar, Advocates

For the Respondent : M/s. P.A.V.V.S. Sarma & Vijayalaxmi Panguluri, Advocates

#### **AWARD**

Sri D. Vijay Kumar who worked as a Badli Filler (who will be referred to as the workman) has filed this petition under Sec. 2A(2) of the Industrial Disputes Act, 1947 against the Respondents M/s. Singareni Collieries Company Ltd., seeking for declaring the dismissal order dated 15.11.2011 issued by the Respondent as illegal, arbitrary and to set aside the same consequently directing the Respondent to reinstate the Petitioner into service duly granting all the consequential benefits such as continuity of service, back wages and all other attendant benefits etc., and such other reliefs as this court may deems fit.

#### **2. The averments made in the petition in brief are as follows:**

The Petitioner was initially appointed as a badli filler in the year 2008, after his father's death in the year 2005. It is submitted that the Petitioner had completed ITI Electrician from Krishi ITI College, Mancherla and also holds valid driving license of LMV and the said fact was brought to the knowledge of the

Respondent company as the Petitioner was unable to perform the present job. The Petitioner has worked for four months and later because of heavy underground physical work as well as lack of knowledge, he was hospitalized. Later, the Petitioner had explained his weakness to the management and requested to change the nature of work from badly worker to electrician work as he is a qualified worker or provide an opportunity in vehicle driving as he holds a valid driving license. It is submitted that, after submission of the above request he stayed at home, as the Respondent management has assured that they will inform him about the change, in the nature of work. Even after more than 8 months when there was no response from the management side he approached the management and the management send him for medical examination on 17.11.2011 and found that this Petitioner is fit to do work from 17.11.2011. Later he was waiting eagerly for an alternate job in the Respondent's company but the Respondent management without giving any opportunity, has initiated ex-parte proceedings by publishing in Sakshi Newspaper by appointing an Enquiry Officer. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved and basing on the erroneous findings of the Enquiry Officer, the Petitioner was dismissed from service vide office order dated 15.11.2011. But without considering any of his submissions, the Petitioner was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Petitioner from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Petitioner has rendered three years of continuous service in the Respondent's management till his dismissal from service. The Petitioner approached the Respondent to consider his case sympathetically, but the management did not pay any heed to it. Therefore, the Petitioner was constrained to approach this Tribunal to declare the impugned order dated 15.11.2011 issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondents to reinstate the Petitioner into service duly granting all other attendant benefits such as continuity of service, back wages etc..

**3. The Respondent filed counter denying the averments made in the petition, with the averments in brief which runs as follows:**

In the counter the Respondent while admitting some of the factual aspects of the case to be true, stated that the Petitioner was appointed in the Respondent's company on 13.8.2008 as a Badli Coal Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Petitioner did not attend the dates fixed for the enquiry. He was given full, fair and reasonable opportunity to defend himself in the enquiry. The enquiry was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Petitioner was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Petitioner by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Petitioner is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view and lastly, the Respondent was constrained to dismiss the Petitioner from service. It is stated that in fact the Petitioner was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Petitioner is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner not to dispute the validity of the domestic enquiry conducted by the Respondent, the domestic enquiry conducted by the Respondent management is held as legal and valid vide order dated 30.1.2018.

5. Both the parties have advanced their arguments U/s.11A of the Industrial Disputes Act, 1947 in support of their claim.

**6. In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri D. Vijay Kumar is legal and justified?
- II. Whether the Petitioner is entitled for reinstatement into service?
- III. If not, to what other relief the Petitioner is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Petitioner submitted that due to his illness, the Petitioner could not be able to attend his duty sincerely and also awaited for reply from the Respondent for consideration of his request regarding change in the nature of duties. Even in his show cause the Petitioner has mentioned the above facts but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Petitioner. When the Petitioner has taken a stand that due to his inability to perform duty as Badli Filler and requested to change his nature of duties to that of a Driver or an Electrician, he could not be able to attend his duties regularly and remained absent, but in such a case, the authority should have considered his case while



imposing capital punishment. But the authority has not considered any of the submissions of the Petitioner, and has imposed capital punishment to the Petitioner when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent submitted that when the Petitioner was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Petitioner was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his inability to perform duty as Badli Filler and request to change his nature of duties to that of a Driver or an Electrician, he could not be able to regular in his duty, and remained absent in his duties and also one proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Petitioner were proved. For this, capital punishment was imposed. After dismissal of service, the Petitioner has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 35 years, he is now aged about 42 years and is searching ways and means to provide bread and butter to his family members. The Petitioner being an able bodied and energetic man has already realised his mistake and is coming forward to the court at the age of 42 years to work under the Respondent. In such a circumstances, atleast one chance should be given to him for his reinstatement into service in order to save his family members. Admittedly several modes of punishment are enumerated in company's Standing Orders. The Petitioner is a first offender and has worked about two years under the Respondent. While imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent for dismissal of service of the Petitioner is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri D. Vijay Kumar is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri D. Vijay Kumar is not legal and justified. After dismissal of service as stated earlier, when the Petitioner has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Petitioner has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Petitioner should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Petitioner has not come to the court soon after his dismissal of service. In the opinion of this Tribunal the Petitioner is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **ORDER**

Proceeding No. SRP/PER/13.008/4149 dated 15.11.2011 issued by Respondent is declared as illegal and is hereby set aside. It is ordered that the workman Sri D. Vijay Kumar be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman can not claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc.. to the workman for appointment afresh.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 19<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### Appendix of evidence

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

### Documents marked for the Petitioner

NIL

### Documents marked for the Respondent

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 710.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण—सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या एल सी 144/2013) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22013/01/2020-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 710.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award ( Ref. No. LC 144/2013) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22013/01/2020-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

### ANNEXURE

### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 20<sup>th</sup> day of February, 2020

### INDUSTRIAL DISPUTE L.C.No. 144/2013

**Between:**

Sri Jupelli Mallesh,  
S/o Late Satyanarayana,  
R/o 9-7-165, Birlipit Area,  
Kothagudem -507101.  
Khammam District.

...Petitioner



**AND**

1. The Director (P.A. & W),  
M/s. Singareni Collieries Company Ltd.,  
5 Incline, Rudrampur,  
Kothagudem Area, Khammam district.
2. The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
5 Incline, Rudrampur,  
Kothagudem Area, Khammam district.

... Respondents

**Appearances:**

For the Petitioner : M/s. Mohd. Yousufuddin &amp; S. Sathyanarayana, Advocates

For the Respondent : M/s. P.A.V.V.S. Sarma &amp; Vijaya Laxmi Panguluri, Advocates

**AWARD**

Sri Jupelli Mallesh who worked as a General mazdoor (who will be referred to as the workman) has filed this petition under Sec. 2A(2) of the Industrial Disputes Act, 1947 against the Respondents M/s. Singareni Collieries Company Ltd., seeking for declaring the proceeding No. KGM/PER/7/376 dated 12.2.2010 issued by Respondent No.2 as illegal, arbitrary and to set aside the same consequently directing the Respondents to reinstate the Petitioner into service duly granting all the consequential benefits such as continuity of service, back wages and all other attendant benefits etc., and such other reliefs as this court may deems fit.

**2. The averments made in the petition in brief are as follows:**

It is submitted that the Petitioner was initially appointed as a Badli Filler on piece rate basis in the month of November, 1990 and he was promoted as General mazdoor category-II. But the Petitioner could not be regular to his duties due to diabetes in the year 2008 and took treatment in SCCL hospital, Kothagudem and on some occasions he took treatment in private hospitals. Though he has submitted leave applications on a few occasions to the Respondent, those are not available with the applicant. While the matters stood thus, charge sheet dated 26.2.2009 was issued to the Petitioner by the Respondents alleging that the Petitioner absented for duty during the year 2008, which amounts to misconduct under company's Standing Order No.25.25. Subsequently, one inquiry was conducted and during the time of the enquiry, the Petitioner was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved and basing on the erroneous findings of the Enquiry Officer, the Petitioner was dismissed from service vide order dated 26.2.2009. It is stated that during the course of the enquiry the Petitioner has categorically stated about his inability to perform his duties regularly during the above said period as it was only on account of his ill-health. But without considering any of his submissions, the Petitioner was dismissed from service. It is also stated that the action of the Respondents management in dismissing the Petitioner from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Petitioner has rendered 19 years of continuous service in the Respondents' management. The Petitioner approached the Respondents to consider his case sympathetically, but the management did not pay any heed to it. Therefore, the Petitioner was constrained to approach this Tribunal to declare the impugned order dated 26.2.2009 issued by the Respondents is illegal and arbitrary and to set aside the same and consequently to direct the Respondents to reinstate the Petitioner into service duly granting all other attendant benefits such as continuity of service, back wages etc..

**3. The Respondents filed counter denying the averments made in the petition, with the averments in brief which runs as follows:**

In the counter the Respondents while admitting some of the factual aspects of the case to be true, stated that the Petitioner was appointed in the Respondents' company on 21.11.1990 as a Badli Filler, and later he was drafted as General Mazdoor in the year 1995 in Category-I. He was dismissed from service on 12.2.2010 and the consequential order dated 18.8.2010 on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Petitioner has attended the dates fixed for the enquiry fixed and had fully participated in the enquiry. He was given full, fair and reasonable opportunity to defend himself in the enquiry. The enquiry was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, he submitted his report holding the charges levelled against the Petitioner was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Petitioner by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Petitioner is

proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view and lastly, the Respondents were constrained to dismiss the Petitioner from service. It is stated that in fact the Petitioner was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show-cause notice. It is further stated that the punishment imposed on the Petitioner is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. The domestic enquiry conducted by the Respondents is held as legal and valid vide order dated 14.7.2017.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

6. **In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Jupelli Mallesh is legal and justified?
- II. Whether the Petitioner is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Petitioner submitted that due to his illness, the Petitioner could not be able to attend his duty sincerely. Even in his show cause the Petitioner has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Petitioner. When the Petitioner has taken a stand that due to his illness, death of his father and wife and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing punishment. The authority has not considered any of the submissions of the Petitioner, and has given capital punishment to the Petitioner when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondents submitted that when the Petitioner was a chronic absentee and was found guilty in the charges levelled against him, the punishment imposed by the Respondents' company is legal and proper. When the Petitioner was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated in service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his illness, death of his father and wife, and other family problems, the Petitioner could not be able to be regular in his duty, the Petitioner has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Petitioner were proved. For this, capital punishment was imposed. After dismissal of service, the Petitioner has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 44 years, he is now aged about 51 years and is searching ways and means to provide bread and butter to his family members. When the Petitioner being an able bodied and energetic man and has already realised his mistake and is also coming forward to work under the Respondents, atleast one chance should be given to him for reinstatement into service. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Petitioner is not a first offender but has worked for about 20 years under the Respondents. While imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondents for dismissal of service is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Jupelli Mallesh is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Jupelle Mallesh is not legal and justified. After dismissal of service as stated earlier, when the Petitioner has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Petitioner has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Petitioner should be given a chance to maintain his livelihood and to work under the Respondents' management. But in this case, the Petitioner has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Petitioner is not entitled

to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **ORDER**

Proceeding No. KGM/PER/7/376 dated 12.2.2010 and the consequential order dated 18.8.2010 issued by Respondent Company is declared as illegal and is hereby set aside. It is ordered that the workman Sri Jupelle Mallesh be taken into service as a fresh employee i.e., an Badli Filler on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman can not claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman will not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry, and in case the workman completes the one year probation period successfully he will continue in service till the age of his superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc., to the workman for appointment afresh.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 20<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### **Appendix of evidence**

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

### **Documents marked for the Petitioner**

NIL

### **Documents marked for the Respondent**

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 711.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 244/2014) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/72/2014-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 711.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 244/2014) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020

[No. L-22012/72/2014-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

## ANNEXURE

### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 20<sup>th</sup> day of February, 2020

#### INDUSTRIAL DISPUTE No. 244/2014

#### **Between:**

The President (Bandari Satyanaryana),  
Rashtriya Collieries Mazdoor Sangh (RCMS)  
Rajkumar Complex, Saibaba Temple Road,  
Jaffar Nagar, Mancheria – 504 208.

...Petitioner/Union

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Sreerampur Area, Sreerampur,  
Adilabad district – 504303.

...Respondent

#### **Appearances:**

For the Petitioner : M/s. Sangars Bhagawanth Rao & S.V. Rama Devi, Advocates

For the Respondent : M/s. Nandigam Krishna Rao, N.S. Pattabhi Rama Rao & J. Narsimhulu, Advocates

#### **AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L-22012/72/ 2014 -IR(CM-II) dated 25.11.2014 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Sreerampur Area, Sreerampur Adilabad Dist., in terminating the services of Sri Muthe Mallaiah, Ex-CF, RK-5 Inc., Sreerampur Area, with effect from 6.1.2005 is justified or not? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 244/2014 and issued notices to both the parties and secured their presence.

#### **2. The Petitioner Union filed claim statement with the averments in brief as follows:**

It is submitted in the representation of the Petitioner Union that, the workman Sri Muthe Mallaiah was initially appointed on 14.4.1987 as a Coal Filler. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, the workman could not attend to his duties during the year 2003 due to his ill-health. While the matters stood thus, he was issued with a charge sheet dated 10.9.2004 alleging that the workman remained absent during the year 2003, which amounts to misconduct under company's Standing Order No. 25.25. Subsequently, one enquiry was conducted and the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service w.e.f. 6.1.2005 vide office order dated 4.1.2005. It is stated that the Workman has



categorically stated about his inability to perform his duties regularly during the year 2003, which was only on account of his ill-health, and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 18 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the Respondent management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

3. **Respondent filed counter with the averments in brief which runs as follows:**

In the counter the Respondent while admitting some of the factual aspects of the case to be true, stated that the Workman was appointed in the Respondent's company on 14.4.1987 as a Coal Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman attended the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view, and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. The domestic enquiry conducted by the Respondent is held legal and valid vide order dated 26.7.2018.

5. I have already heard the Learned Counsels for both the sides in this matter and both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

6. **In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Muthe Mallaiah is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that due to his ill-health, and other family problems, the Workman could not be able to attend his duty sincerely. Even in his show-cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case sympathetically while imposing capital punishment, but, the authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his illness, and other family problems, the Workman could not be able to be regular in his duty, the

Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 49 years, he is now aged about 55 years and is searching ways and means to provide bread and butter to his family members. When the Workman being an able bodied and energetic man and has already realised his mistake and is coming forward to work under the Respondent, atleast one chance should be given to him for reinstatement into service at the end of his service period. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Workman is a first offender and has worked for about 16 years under the Respondent, while imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent management for dismissal of service is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Muthe Mallaiah is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Muthe Mallaiah is not legal and justified. After dismissal of service as stated earlier, when the Workman has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Workman has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Workman should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Workman has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Workman is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the General Manager, M/s. Singareni Collieries Company Ltd., Sreerampur Area, Sreerampur Adilabad Dist., in terminating the services of Sri Muthe Mallaiah, Ex-CF, RK-5 Inc., Sreerampur Area, with effect from 6.1.2005 is not justified and is hereby set aside. It is ordered that the workman be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman cannot claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc.. to the workman for his appointment afresh and as such the reference is answered accordingly. So also the, award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 20<sup>th</sup> day February, 2020.

MURALIDHAR PRADHAN, Presiding Officer



**Appendix of evidence**

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

**Documents marked for the Workman**

NIL

**Documents marked for the Respondent**

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 712.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मचारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 242/2014) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/73/2014-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S.O. 712.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 242/2014) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/73/2014-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD**

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 20<sup>th</sup> day of February, 2020

**INDUSTRIAL DISPUTE No. 242/2014****Between:**

The President (Bandari Satyanaryana),  
Rashtriya Collieries Mazdoor Sangh (RCMS)  
Rajkumar Complex, Saibaba Temple Road,  
Jaffar Nagar, Mancheri - 504 208.

...Petitioner/Union

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Sreerampur Area, Sreerampur,  
Adilabad district - 504208.

...Respondent

**Appearances:**

For the Petitioner : M/s. Sangars Bhagawanth Roa & S.V. Rama Devi, Advocates

For the Respondent : M/s. Nandigam Krishna Rao, N.S. Pattabhi Rama Rao & J. Narsimhulu, Advocates

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L-22012/73/ 2014-IR(CM-II) dated 25.11.2014 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Sreerampur Area, Sreerampur Adilabad Dist., in terminating the services of Sri Medi Narsaiah, Ex-Coal Filler, SRP-3 & 3A, Sreerampur Area, with effect from 1.5.2005 is justified or not? If not, to what relief the applicant is entitled for?

After receiving the above said reference this Tribunal registered the case as I D No. 242/2014 and issued notices to both the parties and secured their presence.

**2. The Petitioner Union filed claim statement with the averments in brief which runs as follows:**

It is submitted in the representation of the Petitioner Union that, the workman Sri Medi Narsaiah was initially appointed on 1.1.1989 as Badli Filler. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, the workman could not attend to his duties during the year 2003 due to his ill-health. While the matters stood thus, he was issued with a charge sheet dated 4.2.2004 alleging that the workman remained absent during the year 2003, which amounts to misconduct under company's Standing Order No.25.25. Subsequently, one enquiry was conducted and the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service w.e.f. 1.5.2005 vide office order dated 27.4.2005. It is stated that the Workman has categorically stated about his inability to perform his duties regularly during the year 2003, which was only on account of his ill-health, and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 16 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the Respondent management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

**3. The Respondent filed counter with the averments in brief which runs as follows:**

In the counter the Respondent while admitting some of the factual aspects of the case to be true, stated that the Workman was appointed in the Respondent's company on 10.1.1989 as Floating Badli Filler and regularized as Coal Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman attended the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view, and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. The domestic enquiry conducted by the Respondent is held legal and valid vide order dated 26.7.2018.

5. I have already heard the Learned Counsels for both the sides in this matter and both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

**6. In view of the above facts, the points for determination of this case are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Medi Narsaiah is legal and justified?

II. Whether the Workman is entitled for reinstatement into service?

III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that due to his ill-health, and other family problems, the Workman could not be able to attend his duty sincerely. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case sympathetically while imposing capital punishment. But in this case the authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his illness, and other family problems, the Workman could not be able to be regular in his duty, the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 49 years, he is now aged about 55 years and is searching ways and means to provide bread and butter to his family members. When the Workman being an able bodied and energetic man and has already realised his mistake and is coming forward to work under the Respondent, atleast one chance should be given to him for reinstatement into service at the end of his service period. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Workman is a first offender and has worked for about 16 years under the Respondent, while imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent management for dismissal of service is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Medi Narsaiah is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Medi Narsaiah is not legal and justified. After dismissal of service as stated earlier, when the Workman has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Workman has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Workman should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Workman has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Workman is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the General Manager, M/s. Singareni Collieries Company Ltd., Sreerampur Area, Sreerampur Adilabad Dist., in terminating the services of Sri Medi Narsaiah, Ex-Coal Filler, SRP-3 & 3A, Sreerampur Area, with effect from 1.5.2005 is not justified and is hereby set aside. It is ordered that the workman be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman cannot claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc.. to the workman for his appointment afresh and as such the reference is answered accordingly. So also the, award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 20<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Presiding Officer

#### Appendix of evidence

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

#### Documents marked for the Workman

NIL

#### Documents marked for the Respondent

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 713.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मैसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मचारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण - सह - श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 49/2013) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/24/2013-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 713.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 49/2013) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/24/2013-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 18<sup>th</sup> day of March, 2020**INDUSTRIAL DISPUTE No. 49/2013****Between:**

The General Secretary (Sh. Riaz Ahmed),  
Singareni Miners & Engg. Workers Union (HMS),  
Qr.No. C-34, Sector-I, Godavarikhani.  
Karimnagar District-505209.

...Petitioner/Union

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Mandamarri Area, Mandamarri,  
Adilabad district -504 231.

...Respondent

**Appearances:**

For the Petitioner : M/s. A. Sarojana &amp; K. Vasudeva Reddy, Advocates

For the Respondent : M/s. P.A.V.V.S. Sarma &amp; Vijaya Laxmi P., Advocates

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L-22012/24/2013-IR(CM-II) dated 23.4.2013 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the Chief General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Mandamarri, Adilabad Distt. in terminating the services of Sri Md. Mohammed, Ex-Badli Filler, KK-5 Inc., SCCL, Mandamarri Area, with effect from 18.1.2000 is justified? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 49/2013 and issued notices to both the parties and secured their presence.

**2. The Petitioner Union filed claim statement with the averments in brief as follows:**

It is submitted in the representation of the Petitioner Union that, the workman Sri Md. Mohammed was initially appointed as a Badli Coal Filler on 20.6.1994. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, during the year 1998, the workman's wife suffered with severe ill-health, which caused mental agony to the workman. The workman accompanied his wife to various hospitals for treatment. Further, during the same time, the mother-in-law of the concerned workman expired and his father-in-law also remarried. These incidents also had an effect on the health of his wife, as a result of which, he could not be regular to his duties during the year 1998. While the matters stood thus, he was issued with a charge sheet dated 5.3.1999 alleging that the workman remained absent during the year 1998, which amounts to misconduct under company's Standing Order No.25.25. Subsequently, one enquiry was conducted and the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service with effect from 18.1.2000 vide office order dated 9.1.2000. It is stated that the Workman has categorically stated about his inability to perform his duties regularly during the year 1998, which was only on account of his wife's ill-health and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered 6 years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the Respondent management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..



3. **Respondent filed counter with the averments in brief as follows:**

In the counter the Respondent while admitting some of the factual aspects to be true, stated that the Workman was appointed in the Respondent's company on 20.6.1994 as a Badli Filler. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman attended the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view, and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner stating that the Petitioner is not interested to challenge the validity of the domestic enquiry conducted by the Respondent, and lastly the domestic enquiry conducted by the Respondent is held legal and valid vide order dated 6.3.2019.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

6. **In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Md. Mohammed is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that, during the year 1998, the workman's wife suffered with severe ill-health, which caused mental agony to the workman. The workman accompanied his wife to various hospitals for treatment. Further, during the same time, the mother-in-law of the concerned workman expired and his father-in-law also remarried. These incidents also had an effect on the health of his wife, as a result of which, he could not be regular to his duties during the year 1998. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his wife's illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing capital punishment. The authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to the ill-health of the workman's wife and other family problems, the Workman could not be able to regular in his duty, the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 42 years, he is now aged about 49 years and is searching ways and means to provide bread and butter to his family members. When the Workman being an able bodied and energetic man and has already realised his mistake and is coming forward to work under the Respondent, atleast one chance should be given to him for his reinstatement into service at the end of his service period. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Workman is a first offender and has worked for about 6 years under the Respondent, while imposing capital punishment to his



employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent management for dismissal of service is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Md. Mohammed is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No.I, it has already been discussed that the punishment of dismissal from service to Sri Md. Mohammed is not legal and justified. After dismissal of service as stated earlier, when the Workman has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Workman has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Workman should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Workman has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Workman is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the Chief General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Mandamarri, Adilabad Dist., in terminating the services of Sri Md. Mohammed, Ex-Badli Filler, KK-5 Inc., SCCL, Mandamarri Area, with effect from 18.1.2000 is not justified and is hereby set aside. It is ordered that the workman be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman cannot claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc.. to the workman for his appointment afresh and as such the reference is answered accordingly. So also the, award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 18<sup>th</sup> day March, 2020.

MURALIDHAR PRADHAN, Presiding Officer

### **Appendix of evidence**

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

### **Documents marked for the Workman**

NIL

Documents marked for the Respondent

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 714.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधतंत्र के संबद्ध नियोजकों और उनके कर्मकारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण-सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 42/2016) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/58/2016-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 714.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 42/2016) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/58/2016-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 24<sup>th</sup> day of February, 2020**INDUSTRIAL DISPUTE No. 42/2016****Between:**

Sri Sidda Anjaiah,  
Batvanpalli(V)  
Bellampalli  
Adilabad Dist-504251.

...Petitioner

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Sreerampur Area, Sreerampur  
Adilabad – 504303.

...Respondent

**Appearances:**

For the Petitioner : None

For the Respondent : M/s. Nandigam Krishna Rao, N.S. Pattabhi Rama Rao & N. Dasaradha Ramulu,  
Advocates

**AWARD**

The Government of India, Ministry of Labour by its order No. L-22012/58/2016-IR(CM-II) dated 19.10.2016 referred the following dispute between the management of M/s. Singareni Collieries Company Ltd., and their workman under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal. The reference is,

**SCHEDULE**

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Sreerampur Area, Sreerampur, Adilabad Dist., in terminating the services of Sri Sidda Anjaiah, Ex-Coal Filler, 3 & 3A Inc., SCCL Sreerampur Area Sreerampur with effect from 8.1.2005 is justified or not? If not, to what relief the applicant is entitled for?”

The reference is numbered in this Tribunal as I.D. No. 42/2016 and notices were issued to the parties concerned.

2. The case was posted for filing of claim statement by the Petitioner but, notices served on the Petitioner returned unserved. Non appearance of the Petitioner and non taking of any steps to pursue his case clearly indicates that perhaps the Petitioner is not interested to pursue his case. In the circumstances stated above, it is not desirable to linger the case to date to date awaiting the appearance of the Petitioner. Hence, the case of the Petitioner workman is closed and a 'No dispute' award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P Phani Gowri, Personal Assistant and corrected by me on this the 24<sup>th</sup> day of June, 2019.

MURALIDHAR PRADHAN, Presiding Officer

#### Appendix of evidence

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

#### Documents marked for the Petitioner

NIL

#### Documents marked for the Respondent

NIL

नई दिल्ली, 14 अगस्त, 2020

**का.आ. 715.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण—सह-श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 18/2014) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/171/2013-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 715.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 18/2014) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/171/2013-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

**ANNEXURE****IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT  
HYDERABAD****Present:** Sri Muralidhar Pradhan, Presiding OfficerDated the 20<sup>th</sup> day of February, 2020**INDUSTRIAL DISPUTE No. 18/2014****Between:**

The General Secretary (Sh. Riaz Ahmed),  
Singareni Miners & Engg. Workers Union (HMS),  
Qtr.No.C-34, Sector-I, Godavarikhani.  
Karimnagar District-505209.

...Petitioner/Union

**AND**

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Mandamarri Area, Mandamarri,  
Adilabad district – 504231.

...Respondent

**Appearances:**

For the Petitioner : M/s. A. Sarojana &amp; K. Vasudeva Reddy, Advocates

For the Respondent : Sri V.S.V.S.R.K.S. Prasad, Advocate

**AWARD**

This is a reference issued by the Government of India, Ministry of Labour and Employment, New Delhi vide order No.L-22012/171/2013-IR(CM-II) dated 10.2.2014 whereunder this Tribunal is required to adjudicate the dispute i.e.,

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Mandamarri in terminating the services of Sri Janga Rajendra Kumar, Ex-Badli Filler, Kasipeta Mine, Mandamarri Area, with effect from 26.10.2009 is justified or not? If not, to what relief the applicant is entitled for?”

After receiving the above said reference this Tribunal registered the case as I D No. 18/2014 and issued notices to both the parties and secured their presence.

**2. The Petitioner Union filed claim statement with the averments in brief as follows:**

It is submitted in the representation of the Petitioner Union that, the workman Sri Janga Rajendra Kumar was initially appointed on 1.12.2007 as a Badli Filler. He was regular to his duties and performing his duties upto the satisfaction of all his superiors. While so, the cousin of the workman who had been living with him, died in the year 2008 and the incident had disturbed his life a lot. While the matters stood thus, he was issued with a charge sheet dated 10.1.2009 alleging that the workman remained absent during the year 2008, which amounts to misconduct under company's Standing Order No.25.25. Subsequently, one enquiry was conducted and the Workman was not given any opportunity much less valid in nature to put forth his grievances. Basing on such lopsided enquiry, the Enquiry Officer held the charges as proved, and basing on the erroneous findings of the Enquiry Officer, the Workman was dismissed from service w.e.f. 26.10.2009 vide office order dated 13.10.2009. It is stated that the Workman has categorically stated about his inability to perform his duties regularly during the year 2008, which was only on account of his ill-health, his cousin's death and other family problems. But without considering any of his submissions, the Workman was dismissed from service. It is also stated that the action of the Respondent's management in dismissing the Workman from service is wholly illegal, arbitrary, violative of the principles of natural justice. The Workman has rendered two years of continuous service in the Respondent's management. The Workman approached the Respondent to consider his case sympathetically, but the Respondent management did not pay any heed to it. Therefore, the Workman was constrained to approach this Tribunal to declare the impugned order issued by the Respondent is illegal and arbitrary and to set aside the same and consequently to direct the Respondent to reinstate the Workman into service duly granting all other attendant benefits such as continuity of service, and back wages etc..

3. **Respondent filed counter with the averments in brief as follows:**

In the counter the Respondent while admitting some of the factual aspects of the case to be true, specifically stated that the Workman was appointed in the Respondent's company on 29.11.2007 as Badli Filler and continued in the same designation without regularization of his services till his dismissal. He was dismissed from service on proved charges of absenteeism, after conducting a detailed domestic enquiry duly following the principles of natural justice. The Workman attended the enquiry, which was conducted purely following the principles of natural justice. It is stated that basing on the evidence adduced before the Enquiry Officer, the Enquiry Officer submitted his report holding the charges levelled against the Workman was proved. A copy of the enquiry report and the enquiry proceeding was sent to the Workman by way of show cause notice giving him an opportunity to make representation against the findings of the enquiry report; since the charge levelled against the Workman is proved and it was serious in nature, punishment warranted was dismissal from service. The Disciplinary Authority has gone through the enquiry proceeding and his past record and found that there was no extenuating circumstances to take a lenient view, and lastly, the Respondent was constrained to dismiss the Workman from service. It is stated that in fact the Workman was irregular to his duties and he did not improve his attendance even after issuing charge sheet to him, and after receiving the show cause notice. It is further stated that the punishment imposed on the Workman is justified and legal and as such the claim petition is liable to be dismissed in limini.

4. In view of the memo filed by the Learned Counsel for the Petitioner stating that the Petitioner is not interested in prosecuting the issue of validity of the domestic enquiry conducted by the Respondent, and as such the domestic enquiry conducted by the Respondent is held legal and valid vide order dated 19.12.2016.

5. Both the parties have advanced their arguments under Sec.11(A) of the Industrial Disputes Act, 1947, in support of their claim.

6. **In view of the above facts, the points for determination are:**

- I. Whether the action of the management of M/s. Singareni Collieries Company Ltd., in imposing the punishment of dismissal from service to Sri Janga Rajendra Kumar is legal and justified?
- II. Whether the Workman is entitled for reinstatement into service?
- III. If not, to what other relief he is entitled?

7. **Point No. I:** During the course of argument, the Learned Counsel appearing on behalf of the Workman argued that due to his ill-health, also death of the cousin of the workman, and other family problems, the Workman could not be able to attend his duty sincerely. Even in his show cause the Workman has mentioned the above fact, but it has not been considered during the course of the enquiry and on account of absenteeism capital punishment of dismissal from service was imposed on the Workman. When the Workman has taken a stand that due to his illness and other family problems he could not be able to attend his duties regularly and remained absent, the authority should have considered his case while imposing capital punishment. The authority has not considered any of the submissions of the Workman, and has given capital punishment to the Workman when several modes of punishment are enumerated in the company's Standing Orders.

8. On the other hand, the Learned Counsel appearing on behalf of the Respondent argued that when the Workman was a chronic absentee and was found guilty of the charges levelled against him, the punishment imposed by the Respondent's company is legal and proper. When the Workman was not sincere in his duty and failed to maintain minimum musters in a year he is not entitled to be reinstated into service.

9. Admittedly, working in the Mines is hazardous and remaining absent is not unusual. In this case, due to his illness, mental agony upon death of his cousin and other family problems, the Workman could not be able to be regular in his duty, the Workman has remained absent in his duties and a proceeding was initiated against him for his absenteeism followed by an enquiry. In the enquiry, the charges levelled against the Workman were proved. For this, capital punishment was imposed on the workman. After dismissal of service, the Workman has become jobless and unable to provide a square meal to his family members. He has already realised his mistake and has taken shelter in the court at the age of 29 years, he is now aged about 35 years and is searching ways and means to provide bread and butter to his family members. When the Workman being an able bodied and energetic man and has already realised his mistake and is coming forward to work under the Respondent, atleast one chance should be given to him for reinstatement into service at the end of his service period. Admittedly several modes of punishment are enumerated in company's Standing Orders. Though the Workman is a first offender and has worked for about 2 years under the Respondent, while imposing capital punishment to his employees, the management should think of the condition of the workers as well as his family members. In this case, the punishment imposed by the Respondent management for dismissal of service



is too harsh. Therefore, it can safely be stated that the action taken by the management in imposing the punishment of dismissal from service to Sri Janga Rajendra Kumar is not legal and justified.

Thus, Point No.I is answered accordingly.

10. **Point Nos. II & III:** In Point No. I, it has already been discussed that the punishment of dismissal from service to Sri Janga Rajendra Kumar is not legal and justified. After dismissal of service as stated earlier, when the Workman has already realised his mistake and has come to the court with a prayer for reinstatement into service he should be given a chance to serve for his family members. After dismissal of service the Workman has become jobless and he being the sole bread earner of his family, is unable to provide a square meal to his family members. In such a circumstances atleast the Workman should be given a chance to maintain his livelihood and to work under the Respondent's management. But in this case, the Workman has not come to the court soon after his dismissal of service. Therefore, in the opinion of this Tribunal the Workman is not entitled to get all the relief as claimed in his claim petition. But he is only entitled to be given a chance to work in the Respondent's management as a fresh Badli Filler.

Thus, Point Nos. II & III are answered accordingly.

### **RESULT:**

In the result, the action of the Chief General Manager, M/s. Singareni Collieries Company Ltd., Mandamarri Area, Mandamarri in terminating the services of Sri Janga Rajendra Kumar, Ex-Badli Filler, Kasipeta Mine, Mandamarri Area, with effect from 26.10.2009 is not justified and is hereby set aside. It is ordered that the workman be taken into service as a fresh employee i.e., Badli filler in Cat.I, on initial basic pay without back wages and continuity of service, subject to medical fitness by the company Medical Board and the workman be kept under probation for a period of one year. The management is also directed to take an undertaking of good behaviour from the workman at the time of his posting.

The Workman cannot claim for his posting in the same place, where he was last employed. The workman shall have to maintain either minimum mandatory 20 musters every month or 190 musters in a year and the management shall have the right to review the work of the workman in every three months. In the event of any short fall of attendance during the period of the three months, the service of the workman shall not be terminated and he will be cautioned to improve his performance by issuing him a warning letter. However, in the event of any shortfall of attendance during one year of service of the workman, he will be terminated from service without any further notice and enquiry and in the event of completion of one year of probation satisfactorily, the workman is to continue in service till the age of attaining superannuation. The management shall consider any forced absenteeism on account of Mine accidents/ Natural disasters, taking treatment in the company's hospital, as attendance. All other usual terms and conditions of appointment will be applicable i.e., transfer, hours of work, day of rest, holidays etc. to the workman for his appointment afresh and as such the reference is answered accordingly. So also the, award is passed accordingly. Transmit.

Typed to my dictation by Smt. P. Phani Gowri, Personal Assistant and corrected by me on this the 20<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Psresiding Officer

### **Appendix of evidence**

Witnesses examined for the  
Workman

NIL

Witnesses examined for the  
Respondent

NIL

### **Documents marked for the Workman**

NIL

### **Documents marked for the Respondent**

NIL



नई दिल्ली, 14 अगस्त, 2020

**का.आ. 716.**—औद्योगिक विवाद अधिनियम, 1947 (1947 का 14) की धारा 17 के अनुसरण में, केन्द्रीय सरकार मेसर्स सिंगारेनी कोलियरीज कंपनी लिमिटेड के प्रबंधन के संबद्ध नियोजकों और उनके कर्मचारों के बीच, अनुबंध में निर्दिष्ट औद्योगिक विवाद में केन्द्रीय सरकार औद्योगिक अधिकरण – सह - श्रम न्यायालय, हैदराबाद के पंचाट (संदर्भ संख्या 12/2016) को प्रकाशित करती है, जो केन्द्रीय सरकार को 07.07.2020 को प्राप्त हुआ था।

[सं. एल-22012/23/2015-आईआर (सीएम-2)]

राजेन्द्र सिंह, डेस्क अधिकारी/अनुभाग अधिकारी

New Delhi, the 14th August, 2020

**S. O. 716.**—In pursuance of Section 17 of the Industrial Disputes Act, 1947 (14 of 1947), the Central Government hereby publishes the Award (Ref. No. 12/2016) of the Cent.Govt.Indus.Tribunal-cum-Labour Court, Hyderabad as shown in the Annexure, in the industrial dispute between the management of M/s. Singareni Collieries Company Ltd., and their workmen, received by the Central Government on 07.07.2020.

[No. L-22012/23/2015-IR(CM-II)]

RAJENDER SINGH, Desk Officer/Section Officer

### ANNEXURE

#### IN THE CENTRAL GOVERNMENT INDUSTRIAL TRIBUNAL-CUM-LABOUR COURT AT HYDERABAD

**Present:** Sri Muralidhar Pradhan, Presiding Officer

Dated the 24<sup>th</sup> day of February, 2020

#### INDUSTRIAL DISPUTE No. 12/2016

#### Between:

Sri Indugula Venkaty,  
D.No.2-1/4, Battanpalli(V),  
Bellampalli(M), - 504251.  
Adilabad Dist.

...Petitioner

AND

The General Manager,  
M/s. Singareni Collieries Company Ltd.,  
Bellampally Area,  
Goleti Township – 504 292.  
Adilabad Dist.

...Respondent

#### Appearances:

For the Petitioner : None

For the Respondent : M/s. P.A.V.V.S. Sarma & P. Vijaya Laxmi, Advocates

#### AWARD

The Government of India, Ministry of Labour by its order No. L-22012/23/2015-IR(CM-II) dated 22.1.2016 referred the following dispute between the management of M/s. Singareni Collieries Company Ltd., and their workman under section 10(1)(d) of the I.D. Act, 1947 for adjudication to this Tribunal. The reference is,

#### SCHEDULE

“Whether the action of the General Manager, M/s. Singareni Collieries Company Ltd., Bellampalli Area, Adilabad Dist., in terminating the services of Sri Indugula Venkaty, Ex-Badli Filler, Goleti 2 Inc., SCCL Bellampalli Area, with effect from 20.2.1998 is justified or not? If not, to what relief the applicant is entitled for?”

The reference is numbered in this Tribunal as I.D. No. 12/2016 and notices were issued to the parties concerned.

2. The case was posted for filing of claim statement by the Petitioner.

3. In spite of service of notices, the Petitioner did not turn up to file claim statement nor come forward pursue his case. Non appearance of the Petitioner and non taking of any steps to pursue his case clearly indicates that perhaps the Petitioner has no claim to raise and perhaps the matter has already been settled between the parties. In the circumstances stated above, it is not desirable to linger the case to date to date awaiting the appearance of the Petitioner. Hence, the case of the Petitioner workman is closed and a 'No dispute' award is passed.

Award is passed accordingly. Transmit.

Typed to my dictation by Smt. P Phani Gowri, Personal Assistant and corrected by me on this the 24<sup>th</sup> day of February, 2020.

MURALIDHAR PRADHAN, Presiding Officer

#### Appendix of evidence

Witnesses examined for the  
Petitioner

NIL

Witnesses examined for the  
Respondent

NIL

#### Documents marked for the Petitioner

NIL

#### Documents marked for the Respondent

NIL

नई दिल्ली, 18 अगस्त, 2020

**का.आ. 717.**—राष्ट्रपति, न्यायधीश (सेवानिवृत्त) रत्नाकला, पीठासीन अधिकारी, केन्द्रीय सरकार औद्योगिक अधिकरण सह श्रम न्यायालय, बेंगलोर को दिनांक 22.8.2020 से छः माह तक की अवधि अथवा नियमित पदाधिकारी के पदभार ग्रहण करने तक अथवा अगले आदेशों तक केन्द्रीय सरकार औद्योगिक अधिकरण सह श्रम न्यायालय, हैदराबाद के पीठासीन अधिकारी के पद का अतिरिक्त प्रभार सौंपते हैं।

[सं. अ-11016/05/2020-सीएलएस-II]

एस.के. कालड़ा, उप सचिव

New Delhi, the 18th August, 2020

**S.O. 717.**—The President is pleased to entrust the additional charge of the post of Presiding Officer, Central Government Industrial Tribunal-cum-Labour Court, Hyderabad to Justice(Retd.) Rathnakala, Presiding Officer, Central Government Industrial Tribunal-cum-Labour Court, Bangalore for a period of six months with effect from 22.08.2020 or till joining of a regular incumbent or until further orders, whichever is the earliest.

[No. A-11016/05/2020-CLS-II]

S. K. KALRA, Dy. Secy.